

ASSESSING “CLINICAL IDENTITY” THROUGH THE LENSES OF CHOICE, COGNITION, AND  
CONTEXT-IMPLICATIONS FOR MARGINAL MEN IN TREATMENT

by

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In memory of

Dr. Chris Peterson, PhD and Susan Campbell

&

Dedicated to the several now deceased family members and friends who supported and inspired  
me throughout the course of this academic pursuit

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*In all your ways acknowledge [God] and He shall direct your paths (Proverbs 3:6 NKJV)*

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## **ABSTRACT**

Utilizing a treatment sample comprised solely of urban adult Black male participants in residential substance abuse treatment programs for substance use disorders, this dissertation sheds light on the reported perceptions of men multiply marginalized by the intersection of race, gender, ascribed pathology and placement in residential treatment facilities. By incorporating aspects of intersectionality theory and the main components of the Lifestyle Theory Model of Recovery, this dissertation examines the identities of an extra-marginalized and atypical subset of the larger Black male population from three thematic perspectives: Marginal Choice (self-ascription), Marginal Cognition (perceived power), and Marginal Context (racial regard/treatment (physical) setting). Results reveal important intragroup differences in perceived personal control, self-ascription, and racial regard, as well as significant relationships between personal measures of satisfaction and wellbeing, risk taking behavior, and overall treatment adaptation overtime. The implications, costs and benefits of multiple marginalization for Black men in clinical treatment settings are discussed with suggestions as to how to better ensure more successful clinical experiences for marginal Black men who opt to participate in clinical treatment.

## CHAPTER I

### INTRODUCTION

*Marginalization evokes a dynamic between two social analytic categories: the "center" (or mainstream), and an area called the "margins." The center is normally associated with dominance, privilege, and power; the margins, with relative powerlessness. To be marginalized is to be placed in the margins, and thus excluded from the privilege and power found at the center. (Encyclopedia of Public Health, 2012)*

The social marginalization of Black men is well documented and has been historically linked to the cultural, political and economic institution of slavery (Garfield, 2010; Booker, 2000). Through a variety of deficit and subordinate models of manhood, scholars and researchers have historically asserted that racially restrictive systems and gender confining social structures have resulted in the marginal displacement of many men who are Black, placing them in disadvantaged social positions (hooks, 2004; Staples, 2004; Young, 2011). Along with the protracted disparagement and ostracizing conditions resulting from the historical and social interaction of their gendered and raced statuses, a segment of marginal Black men are additionally affected by psychopathology--classifiable and diagnosable mental and behavioral disorders--severe enough to require inpatient and/or residential treatment services (Griffith, Metz, Gunter, 2011; Neighbors, 2008). The socially marginalizing classifications of being Black, male, mentally ill and in need of inpatient/residential treatment not only highlights the

number of multiple stigmatizing and thus marginalizing social classifications many of these men face; but compels the consideration of the qualitatively different and compounding social effects that likely result from this multiple marginalization.

Unfortunately, there is a paucity of empirical studies that have concentrated their attention on better understanding the intersection of race, gender, ascribed pathology and treatment participation. While some studies have highlighted the multiply marginalizing issues related to being Black, male, and mentally, physically and/or behaviorally impaired in treatment (Bowleg, 2013; Neighbors et al. 2008; Jackson et al., 2007; Watkins, 2012), much is still unknown about Black men in treatment. More is needed in better understanding the intersecting impact of occupying multiple marginalized categories on identity and perception while in treatment and its relationship to one's sense of well-being, treatment compliance, style of coping, and proclivity towards risk taking behavior both progressively and contextually. Furthermore, for a population often characterized based on its deficits, little remains known about the dispositional circumstances that distinguishes those who are resilient and successful in treatment despite their multiply marginalized status (Fortney et al., 2004; Furst, Johnson, Dunlap, & Curtis, 1999).

### **Marginalization Defined**

Marginalization is characterized as a "slippery and multilayered" concept (Kagan & Burton, 2004). It has been defined as the condition of ". . . being outside the mainstream of productive activity and/or social reproductive activity" (Leonard, 1984, p.180) and a state of "peripheral or disadvantaged unequal membership and disparate treatment" (Cheng, 1999, p. 1). Social marginalization, the focus of this dissertation, is a marginalization resulting from one's social identity or social grouping, which can be either ascribed or acquired in society (Kagan &

Burton, 2004). *Ascribed social marginality* refers to those who are characteristically relegated or naturally born into a social group that is historically positioned as marginal, such as certain victimized racial/ethnic groups and/or biological/physically impaired groups. For these individuals marginality can be considered a lifelong state and greatly determines the lived experience. On the other hand, *acquired social marginality* is either a voluntary social positioning (such as participating in certain religious sects) or an abrupt involuntary social placement (such as those who become poor due to economic recession or natural disasters). Whether ascribed or acquired, the effected individuals and groups may be stigmatized and placed on the receiving end of negative public attitudes and social exclusion (Kagan & Burton, 2004). Their opportunities to make social contributions are often limited by social policies and practices, leaving them with inadequate access to valued social resources such as education and health services, housing, income, leisure activities, and employment. In sum, marginalization leaves certain groups and individuals as social deviants; because they are characteristically different from the social norm, socially excluded because of the ostracizing and relational strain that can result from their stigmatizing position, and socially disempowered because of the deprivation of resources that promote self-determination and progress in economic, political and social settings.

Notably, to be socially sanctioned as marginalized does not necessarily mean the individual or individuals considered marginalized concur or view their marginalized status negatively or aversely. Actually, several researchers assert the opinion that marginality does not need to be negative or disruptive, but can be adaptive. In their review of the marginality literature, Del Pilar and Udasco (2004) noted the literature's bifurcated view of marginality. They found some studies support the belief that marginality is inevitably stressful and

deleterious, primarily resulting in strain or distress. On the other hand, some studies assert marginalization encourages positive, if not empowering, adaptation (Mahalingham, 2008). Unger, Palmer, Dent, Rohrbach, and Johnson (2000) found in their study that marginality, for some, turned into activism and served as a positive impetus to tackle political issues and perceived empowerment. Most recently, Ellemers and Jetten (2013) characterize marginality as a negotiation about inclusion between the individual and group. They assert that, depending on individuals' goals and personal perceptions, one can be motivated through the experience of marginalization to either move toward or away from the ill effects of their group's marginalizing status.

Mahalingham (2008) addresses this point in his study of immigrants and the concept of social marginality. He found people in socially marginalized positions and locations negotiated their social status and coped differently and more complexly than those not considered marginalized. This reaction sometimes resulted in negative outcomes such as depressive symptoms, but at times resulted in positive outcomes, such as an increase in positive self-identity, which served as a buffer against negative ethnic discrimination (Mahalingham, 2008). Mahalingham's suggestion of a multi-layered, holistic view of social marginality can be used to study psychological and physical wellbeing outcomes for Black male participants in treatment and better ascertain whether marginal social positions for Black men is an onerous one or a motivating one.<sup>1</sup>

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<sup>1</sup> It is important to note some have argued for the use of the marginality concept be discarded by social scientists because it lacks construct validity (Del Pilar & Udasco, 2004). They argue it has been applied so indiscriminately as to be useless in the social sciences.

<sup>2</sup> Within the disease model, the assumption is that one is genetically predisposed to a disease that is chronic,



## **Rationale for Study**

A number of critically important themes validate and support the overall goals and objectives of this dissertation. First, with limited argument to the contrary, U.S. men, as a social group, have the vast majority of power in the form of money, social influence, and control. Yet, despite their more privileged and higher socioeconomic status in society, men, as a gendered group, are at greater risk than women of disease, injury, and death (Courtenay, 2011; Kilmartin, 2010). Courtenay (2011) links this risk to a gamut of gendered attitudes, behaviors, and cognitions used by men to “be men,” which he characterizes as the “Dying to Be Men” male problem. Courtenay (2011) identifies over 30 health and wellbeing determinants of which men and boys are more likely than women and girls to violate through their gendered behaviors and thought patterns, which often lead to excess morbidity and premature deaths. Traditional masculine ideologies and styles of reacting have so characterized the social responses of many men that several in the scholarly area of men studies have noted the evidence of this “male problem” across several social problems areas, such as crime, education, physical/mental health, sexual behavior, and substance abuse (Courtenay, 2000; Jefferson, 2002; Kahn, 2009; Williams, 2003). This noted influential nature of gender on persistent and pervasive male problem behaviors renders this dissertation’s discussion of men in treatment for problem behaviors an important one.

Second, addressing men’s disproportional representation within many social problem areas from a solely gender aware perspective may be inadequate. Many of these same social problem areas are not simply represented by a majority of men acting in traditionally gendered (masculine) ways, but are often prominently and disproportionately represented by men of color,

namely Black men (Glicken, 2005). Social risks for those who are Black and male are often accentuated and compounded by the additional social, economic, and political factors many in this group face (Courtenay, 2011; Xantos, Treadwell, & Holden, 2012). Black men experience a variety of psychosocial problems at rates disproportionate to their numbers and with a uniqueness that seems to be a part of their lived world, (Williams, 2003; Young, 2004). The nearly 17 million Black men in the United States constitute only a little more than 6 percent of the total population, but they are disproportionately placed in foster care, juvenile detention and special educational programs (Gordon, 1994, Garfield, 2010). In the area of mortality alone, race and gender differences are peculiarly noticeable. For example, men in the United States typically die more than 5 years earlier than women [Department of Health and Human Services [DHHS, 2009]. However, overall, African-American men die 7 years younger than women of all races and 6 years younger than White men (DHHS, 2009) and 1.7 times that of American Indian/Alaska Native men, and 2.4 times that of Asian or Pacific Islander men (DHHS, 2009). Thus, neither race nor gender alone seems sufficient enough to describe the disparate display of “Black male problems” in society today, making a discussion of the intersection of race and gender particularly important. Courtenay (2011, p.230) addresses this point in his reference to a study finding significant differences in help seeking behaviors between Black men, women and other men, when he writes:

As is noted in [the Neighbors and Howard, 1987] study, little is known about the influence of any interactions between gender and race or ethnicity on health behavior because studies often neglect gender when examining race and neglect race when examining gender.

Third, along with the limited attention given to the interaction of race and gender, there is also a problematic tendency in research towards an erroneous and presumptuous notion of

uniformity in the lived experiences of Black men (Griffith et al., 2011; hooks, 2004) or the overreliance on a singular meaning associated with the experiences of [people] by nature of their socially constructed categories of race, social class, or sexual orientation (Abes, Jones, & McEwen, 2007). While numerous studies reference the Black male experience, this is often done by comparing Black men with members of other socially identified groups and without a rigorous or thorough consideration of the intra-group nuances and complexities. This common occurrence is similar to a component of social psychology's social identity theory known as "out-group bias", which is a tendency to view others within a social group as more homogeneous, than different, resulting in generalized attributions of individualistic behavior to the group ( Fiske, 2010). Garfield (2010, p.56) links this view of marginalized Black men with the past and historical perceptions of Black men as "socially indistinguishable from one another...[who] lack identities worth acknowledging." This perspective of overgeneralization, which can perhaps be applied to the study of men overall, results in the precarious oversight of important behavioral and cognitive variations found within the general population of (Black) men. Research suggests that there can be a considerable amount of perceptual heterogeneity within groups, sometimes significantly more so than those discovered in intergroup comparisons (Garfield, 2010; Kimmel & Aronson, 2010).

Fourth, from a clinical standpoint it is precisely this intra-group variability that needs to be better understood in order to develop effective interventions; for in addition to being black and male, many black men suffer from mental and substance use disorders. Many of which are effectively treated through therapeutic interventions within residential settings. At the same time, scholarly pieces in the area of psychology and social work find that many men (Black men in particular) with psychosocial and behavioral problems requiring clinical interventions are

often not common or compliant participants in therapeutic environments (Barry, 2009). They are less likely to seek help through therapeutic intervention and are more likely to express negative attitudes toward individual help seeking (Mahalik, Good & Englar-Carlson, 2003). Black men particularly are less likely to report negative emotions and addictive impulses (Griffith, Allen, & Gunter, 2011) and are less likely to acknowledge health concerns, especially if this acknowledgement will lead to social marginalization and stigma (Kimmel & Aronson, 2010; Lindsey et al., 2006).

It is important to address the causal factors leading to this conspicuous gap between the provision and accessibility of clinical services for men and men's lack of participation in or receptiveness to these clinical services (Grant & Potenza, 2007). Some researchers stress that many treatment, prevention, and risk reduction programs are often ineffective because they do not adequately involve the specific members for which the programs are designed and fail to thoroughly examine the unique and challenging experiences of these populations (Deren et al., 2003). This lack of client involvement in program development may be particularly significant for marginal groups of individuals such as Black men in need of treatment, who have been considered unreachable or uncooperative—a perception, which, unfortunately may dissuade researchers from a diligent and thorough pursuance and examination of this population (Mount, et al., 2012). Much more is needed to definitively understand the within group differences that characterize Black men, and how and why within the population of Black men various behavioral and mental disorders are experienced and expressed differently (McCann & Kim, 2003).

In response to these aforementioned points, this dissertation, from a descriptive and exploratory approach, is an attempt to contribute theoretically to the social marginality and

intersectionality literature and the dearth of literature exploring the differing intragroup effects of gender, race and psychopathology. It also seeks to lend to the scholarly area of men's studies by shedding light on the circumstances that may contribute to multiply marginalized substance abusing Black men's positive sense of wellbeing, penchant for risk taking behavior, and overall treatment response.

### **Target Problem**

Of the many existing social male problems, substance use disorder (SUD) has particularly impacted the lives of many men at an immeasurable cost. Men of all ages are more likely than females to engage in behaviors that increase the risk of disease, injury, and death, namely through the use/overuse of alcohol and other drugs. Recent statistics on this topic find the prevalence of drug and alcohol dependence among men to be twice as high as women (Substance Abuse and Mental Health Services Administration-SAMHSA, 2012). Courtenay (2011) finds that drug use is associated with suicide, homicide, HIV infection, pneumonia, and high-risk sexuality—all of which are more common among men than women.

The Diagnostic and Statistical Manual of Mental Disorders-4<sup>th</sup> Edition (DSM IV-TR, 2000) classified substance use disorder as a mental disorder, characterizing it as a disease and issue of pathology. According to the DSM-IV-TR, substance use disorder (in the name of chemical dependence) is a maladaptive pattern of substance use, leading to clinically significant impairment or distress. With the release of the DSM-5 in 2013, substance use disorder has been reclassified as a Substance Related-Addictive mental disorder. Leaving the criteria nearly the same as its prior/previous definition but removing the distinction between substance abuse and substance dependence, the DSM-5 presents substance use disorder as manifested by the following

(1) tolerance, as defined by either of the following: (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of the substance (2) withdrawal, as manifested by either of the following: (a) the characteristic withdrawal syndrome for the substance (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms (3) the substance is often taken in larger amounts or over a longer period than was intended (4) there is a persistent desire or unsuccessful efforts to cut down or control substance use (5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects (6) important social, occupational, or recreational activities are given up or reduced because of substance use (7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) (DSM IV-TR, 2000, p.155)

From a mental health and public health perspective, substance use disorder is one of the top health issues leading to mortality and morbidity among Black men (Courtenay, 2010). Adult Black men experience substance dependence and abuse at rates slightly higher, but generally comparable to Whites (SAMHSA, 2009). Yet, Black men in substance abuse treatment report the most exposure to drug use in their social environments compared with White men, White women, and Black women, and are more likely to experience their deleterious effects (SAMHSA, 2009; Furman, 2010). Also, within the population of Black men, alcohol and other drugs are significantly associated with increased rates of homicides, arrests, accidents, assaults, and physical illnesses (SAMHSA, 2007). Black men are more likely to reject the concept of alcoholism and drug abuse and often see heavy drinking as a norm and attribute of manhood and camaraderie (Staples, 2004). In summary, illicit drugs and alcohol threaten to decimate a significant portion of the Black male population (Courtenay, 2010; Parham & Davis, 1987).

According to a 2012 Substance Abuse and Mental Health Services Administration (SAMHSA) national survey, 23.5 million people were in need of treatment for drug and/or alcohol abuse or dependence; but approximately 4 million sought treatment. Of those who sought treatment, only 2.3 million received treatment at an inpatient or residential drug treatment facility while the remainder received treatment via intensive outpatient treatment groups, self-help groups (e.g., Alcoholics Anonymous), private doctor's offices, or in a prison or jail. Next to the inability to pay, one of the primary reasons given for not seeking treatment by those who recognized the need for treatment was fear of stigma--that seeking treatment would result in a negative perception within his or her community (SAMHSA, 2008). These results indicate that the fear of negative perception and subsequent marginalization are important factors in deciding whether one will pursue appropriate treatment. More interestingly, the minority of those who do participate in treatment may knowingly be subjecting themselves to a marginalized status.

### **Marginality and Substance Use Disorder**

Research shows that people with mental disorders, including substance use disorders, are more marginalized and stigmatized than those with physical disorders (Baumann, 2007; Corrigan, et al., 2000). Even more so, people with substance use disorders have been reported to elicit more negative reactions and are considered more dangerous than those with other mental illnesses, such as schizophrenia (Corrigan, et al., 2000; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Marie & Miles, 2008). Marie and Miles (2008) found participants in their studies were less willing to engage in a social relationship with someone who was an alcohol abuser or substance dependent, as opposed to those diagnose with either schizophrenia or depression. Accentuating further their marginalization is the general perception that problematic substance use is within the individual's control and the result of personal choice. Crisp, Gelder,

Meltzer and Rowlands (2000) found in their study of public opinion, drug addiction and alcoholism were the two highest rated conditions on dimensions of controllability. In a national survey examining attitudes toward four mental disorders, including alcohol dependence, depression, cocaine dependence, and schizophrenia, the results showed respondents more likely to report those with alcohol and cocaine dependence more dangerous and more likely to be of “bad character” than those diagnosed with schizophrenia or depression (Link et al., 1999). Also in the same study, the majority of respondents endorsed a higher level of social distance from those with alcohol and cocaine dependence than those with depression and/or schizophrenia (Link et al., 1999). Even when participants are given biogenetic explanations or endorsed brain disease explanations as causal, individuals with a substance use disorders were perceived as more dangerous, having a lack of self-control, and unpredictable (Mehta & Farina, 1997). These results suggests that people with substance use disorders face a distinctively arduous social placement, leaving them more likely the victim of social exclusion and marginalization than those with other mental disorders.

The stigmatizing and marginalizing scenario of substance abuse and addiction becomes acutely more complicated when considering Black men with substance use disorders. Socially marginalized and underprivileged Black men enter substance abuse treatment at disproportionately higher rates than Whites and have poorer treatment outcomes (Moos, Moos, & Finney, 2001). Using a sample from Veteran Affairs national outcome data, Black men were 1.58 times more likely to deteriorate post treatment than participants from other racial groups (Moos, Moos, & Finney, 2001). In a qualitative study, Bowser and Bilal (2001) found several themes associated with Black men’s noncompliance in substance abuse treatment programs. Black men were more likely to express internalized beliefs of racial inferiority and the tendency



to connect domination of Black people to Whites. In sum, these findings highlight the important and unique perceptions and needs many marginalized Black men with substance use disorder bring to treatment settings.

### **Theoretical Foundation**

For Black men who are in treatment with substance use disorders, their difficulties may be better understood through the theoretical concept of intersectionality (Hancock, 2007). Intersectionality acknowledges that for some no single identity category satisfactorily describes how and why certain people respond to their social environment, but rather it is the result of the intersection of identities that generate qualitatively different and influential experiences (Shield, 2008; Crenshaw, 2000). This approach dissuades one from taking an either/or approach to such issues as race, class, gender and other social positions. Instead, it suggests that any social position or dimension can be more fully understood when there is an appreciation for the “simultaneous interplay” of social roles at any point in time. People can be “multiple things at the same time” (Pastrana, 2004, p.85).

Promulgating from the movement of feminists and female scholars of color, the concept of intersectionality pushed the notion that “an inclusive view of women’s position should substantively acknowledge the intersections of gender with other significant social identities, most notably race” (Shields, 2008, p. 302). Again, the emphasis here is that there is a qualitative difference within different intersectional positions and these intersections create both oppression and opportunity (Zinn & Dill, 1996). Shields (2007, p. 303) proposes that intersectionality contributes significantly to a more holistic understanding of people because

“...it offers a language for the glaring fact that it is impossible to talk about gender without considering other dimension of social structure/social identity”

and it is “a generally applicable descriptive solution to the multiplying features that create and define social identities.”

According to Stewart and McDermott (2004), there are three central tenets of intersectionality:

- 1) No social group is homogeneous
- 2) People must be located in terms of social structures that capture the power relations implied by those structures, and
- 3) There are unique, non-additive effects of identifying with more than one social group.

Black male substance abusers’ difficulty integrating into a treatment culture may be the result of what the social psychological model identifies as “intersectional invisibility”, coined by Purdie –Vaughns and Eibach (2008). They posit that possessing two or more intersecting subordinate identities render a person “invisible” and their experiences uniquely unappreciated or narrowly understood, relative to those with a single subordinate identity. Their atypical position between intersecting subordinate identities, the authors purport, can result in a distinctive form of oppression and social exclusion, influencing behavior and life choices. Bowleg (2013) found in her studies of African-American men with HIV that sociocultural factors such as race/ethnicity and sexual orientation intersect with traditional notions of masculinity. As a result, these men, situated in multiply oppressed social status groups, were uniquely more susceptible to certain risk taking behaviors than those who may be singularly situated or unsituated in a socially oppressed category. Virgil (2007) argues through his multiple marginality perspective model that the experiences of racial minority men are uniquely complex and definitive. He asserts that when cultural marginalization is coupled with disadvantaged economic conditions, poor racial minority men in the US face the precarious condition of

“multiple marginality,” which can only be understood by taking into account the different and intersecting layers of cultural, ecological, economical, structural marginality and disadvantage. An understanding of this uniquely blended experience of certain Black men in treatment is imperative and necessary, and if ignored, could have problematic implications for effective treatment intervention and services.

When the theoretical perspectives of “intersectional invisibility” and “multiple marginality” are applied to Black men with substance use disorders so severe it necessitates placement in residential or inpatient treatment, one is compelled to ask, what is the “invisible” experience of these men? How does a sample of multiply marginalized Black American men involved in treatment identify with their Blackness, maleness, and illness? In the context of illness, does the admittance and self-ascription to problematic identities in treatment further complicate the lives of Black men who are already marginalized by their status of being Black and male, or does the acceptance of marginalized and potentially ostracizing “clinical” labels and identities in treatment facilitate treatment progress and correlate with positive self-reports of wellbeing and satisfaction? In the context of gender, does a multiply marginalized status in treatment impact perceived sense of power, control and mastery? Does race, in the context of residential treatment, continue to matter for Black men, who are already stigmatized and excluded by addiction and their need for placement in residential treatment? In sum, what is the imminent impact of all these conditions on overall treatment response and personal satisfaction during and after participation in treatment?

Traditionally, intersectionality has explored the interaction between race, gender and social class (Shields, 2008). However, along with addressing these aforementioned questions, this dissertation seeks to expand the notion of intersectionality beyond gender, race and class to

the examination of other socially stigmatizing identities, such as those linked with psychopathology and behavioral disorder.

### **Lifestyle Theory Model of Treatment:**

To provide conceptual structure, this dissertation borrows from The Lifestyle Theory Model of Treatment (Walters, 2006), which offers a descriptive explanation of “marginal” peoples’ habitual and disorderly behavior. Lifestyle Theory, when applied to issues of addiction, looks beyond physiological and biological explanations to explain and clarify behavior and challenges the traditional notion of the disease model<sup>2</sup>, which often characterizes substance abuse treatment programs (Walters, 2006). By using what is called a “structural model” that emphasizes dynamic interactive factors over static situational factors in describing and explaining the behavior of [people] (Walters, 2006), the model, in part, posits that there are three factors that make up a person’s life space, referred to as the three C’s: Choice, Cognition, and Condition (Context). These factors are described as the essential “building blocks” on which a person’s lifestyle (or habitual behaving) is generated. The systemic interaction of these factors is driven by the individual’s existential fear of social exclusion and desire to fit in. The habitual behavior of the drug lifestyle or criminal lifestyle, the model argues, is the result of the dynamic interaction of Choice, Cognition, and Condition. Furthermore, engaging in such behavior shields the individual from the ill effects of social exclusion and rejection, such as social marginalization (Walters, 2006)

The model defines *Choices* as the expressed decisions individuals make with respect to their identification with particular problematic behaviors (in this case alcohol and illicit drug

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<sup>2</sup> Within the disease model, the assumption is that one is genetically predisposed to a disease that is chronic, interminable, and will progressively worsen if left untreated.

use). *Cognitions* are the thinking or construal patterns employed by the individuals in order to cope, which may or may not minimize the seriousness of any negative long term consequences resulting from the problematic behavior. *Conditions* are those internal factors **and** external settings that contribute to future and concurrent problematic behaviors (e.g. drug use) which either augment or abate a person's options in life (Walters, 2006). The Lifestyle Theory model cautions against viewing these factors as isolative and intermittent, but rather to sufficiently view an individual's lifestyle in its entirety, the three C's factors must be considered as interactive and progressively iterative. The model asserts it is through the interaction of conditions, choices and cognitions that behavior is perpetuated or changed and when there is disruption in one or any of the categories the overall style of behavior is summarily changed as well.

In this dissertation, the three aforementioned C's are represented in three separate chapters as the lived experiences of multiply marginalized Black men are discussed. *Choice* is represented by the concept of self-ascription to an illness identity label (the decision a man makes in how he names himself in terms of his psychopathology). *Cognition* is represented and assessed through the exploration of perceived control—an individual's perception and belief concerning his personal agency and mastery over life events. *Condition*, renamed Context for the purposes of this dissertation, is addressed by considering the physical (residential treatment setting as opposed to community setting) and intrapsychic (racial) (public vs. private racial regard) contexts in which individuals find themselves in the selected study. The interactions and assessments of these identified factors across a period of time provide insight to the lifestyle of marginal Black men with substance abuse disorders.

## **Description of the Dissertation Studies**

This dissertation offers three quantitative studies. The first two are complementary and descriptive and are intended to lay a foundation for the third study. Chapter 2 presents the first study, *Marginalized Choice: Self-Ascribed Illness and its Impact on Marginalized Black Men in Treatment*. This study uses survey data to examine the tendency towards self-ascription to the “addict” label among marginalized Black male participants in an urban based substance abuse treatment program and to explore any significant variable association or differences in the areas of reported drug use, treatment compliance and overall wellbeing. This is accomplished through the display of descriptive statistics and the presentation of results from comparative group studies utilizing t-tests, Chi-square tests and logistic regression to determine significant association and predictive values.

Chapter 3 presents the second study, *Marginalized Cognition: Perceived Control and Gendered response among Black Men in Treatment*. This quantitative study examines the prominence of John Henryism (James, 1994), which is a cultural form of active coping and perceived personal control, among marginalized men in treatment. The measure of John Henryism (JH) is used as an indicator of perceived power and isolated autonomy, which are also traits often reflective of or similar to a strict abidance to a traditional masculine style of thinking and behaving (Kimmel, 2004). For this study, the treatment sample is a marginalized group of Black men in treatment divided into two categories (JH and non- JH), based on their cumulative scores on the John Henryism Scale. Through the use of descriptive statistics, variables that distinguish the two subgroups within this marginalized group will be discussed. Additionally, through the use of regression models JH scores are assessed for their correlative and predictive effects on reported drug use, treatment compliance and overall wellbeing.

Next, Chapter 4 presents the third study, *Marginalized Contexts: Exploring the Progressive, Contextual, and Intersectional Role of Race among Marginalized Black Men in Residential Treatment*. This explorative and predictive study tests the interactional effects of racial identity on “addict” self-ascription and perceived control/John Henryism. Furthermore, the model explores the effects of racial identity across two contrasting contexts (i.e. residential and community), while assessing outcomes related to overall wellbeing, reported drug use, and treatment response. Utilizing a statistical model that incorporates logistic regression, quantitative data is used to assess the predictive value of the models and highlights significant differences overtime and across contexts.

Finally, Chapter 5 integrates the major findings from the three studies. The discussion highlights the study findings and includes implications for theory, research and practice with marginalized Black men in treatment for stigmatizing conditions.

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## **CHAPTER II**

### **MARGINALIZED CHOICE:**

#### **Self-Ascribed Illness and its Impact on Marginalized Black Men In Treatment**

##### **Abstract**

When contextually primed and self-ascribed, core identities, such as race and gender, can be influenced and influential in the lived experience of Black men. For the smaller group of Black men in clinical residential treatment programs for behavioral and mental disorders, the additional identity of mental illness and pathology must be negotiated. Little is known about marginal Black male treatment participants' mental representation of illness and the predictive and consequential variables associated with a personal decision to identify with an "illness identity" label, which may be clinically expedient while in treatment, but further marginalizing overall.

This study uses survey data to examine 471 Black men's assertion of Choice, while in treatment for substance use disorders. This study examines 1) the extent to which marginalized Black men in treatment for substance use disorder self-identify with the pathological label of "addict", 2) the indicators that predict this self-labeling and 3) the impact of self-labeling on treatment compliance, other risk taking behaviors, and perceived wellbeing. Results show self-ascription has a somewhat curvilinear relationship to drug use quantity and frequency, and is mainly predicated on relationship status and perceived satisfaction in the areas of finances, sexuality, and personal control. In addition, the study further reveals self-ascription has no

significant relationship to selected risk taking behaviors, is positively related to help receptivity, and is negatively associated with active recovery and overall satisfaction.

## **Introduction**

Research suggests that how and why one self-identifies vary and are often the result of the mutual interaction of context and agency (Cheryan, & Monin, 2005; Stead, McDermott, MacKintosh, & Adamson 2011; Oyserman & Destin, 2010). A person's choice to self-identify with a particular label or grouping is both influenced and influencing. Just as individuals can be shaped and influenced by socially ascribed group affiliations, those groups and norms can be actively contested, discussed, and negotiated by the individuals who comprise them (Taylor, 1992). Since individuals are active respondents and not simply passive recipients of assigned identity positions, social marginal group status is not necessarily deterministic of a subsidiary self-identity. Individuals can self-identify with stigmatized subgroups, but personally reject the negative and pejorative ascriptions associated with the deviant and stigmatizing labels associated with the select group (Beatty, 2004; Crosby, Clayton, Alksnis & Hemker, 1986). With Black American men in treatment showing less follow-up with treatment, lower adherence to physician recommendations, and subsequent worse health than White Americans patients overall (Penner, Dovidio, Edmondson, Dailey, Markova, Albrecht, & Gaertner, 2009; Alegria, Carson, Goncalves, & Keefe, 2011), perhaps the influencing/influential element of group identity choice is an important explanation for Black men's distinctive reaction to treatment engagement and participation.

## **Related Theory and Research**

As a component of social identity theory (Tajfel & Turner, 1986), social identity research provides a rich social psychological history of self-ascription and its resultant impact. Originally defined as “those aspects of an individual’s self-image that derives from the social categories to which he/she belongs, as well as the emotional and evaluative consequences of this group membership” (Tajfel & Turner, 1986, p. 7), social identity has overtime evolved to refer to the categories to which an individual claims membership (regardless of social ascription) as well as the associated labels and meanings associated with those categories (Haslam, Jetten, Postmes, Haslam, 2011). With identity referring to the “awareness of self, self-reflection, and self-esteem and the quality that enables the expression of the individual’s authentic sense of self” (Tajfel & Turner, 1986, p. 8), the theory postulates one’s identity is enhanced and made meaningful through (1) self-identification with social categories (classifications) and (2) recognition of the distinction that results when differentiating oneself from members of other groups.

When core social identities, such as race and gender, are self-ascribed (chosen), they are found to induce associated behaviors (Oyserman, 2012). Ethnic minorities are more likely to react against health related behaviors (e.g. exercise, eating certain healthy foods) when viewed as non-normative for their self-ascribed group (Oyserman, Fryberg, Yoder, 2007). Oyserman (2012) found Black children perform well below their assessed ability in math when reported self-ascribed racial identity was not deemed congruent to math achievement. In the same light, gender identity has been found to be persuasive. Men, who self-ascribe to traditional notions of masculinity and characterize weakness and vulnerability as “unmanly”, are more inhibited in presenting themselves with personal problems or actively seeking/participating in the services of relevant treatment programs ( Addis, Mansfield, & Syzdek, 2010; Courtenay, 2010; Kilmartin,

2010; Wade & Roelen, 2013). Boys and men are less likely to follow through with expected health and academic related activities when they do not feel particular behaviors are appropriately gender based and identity congruent (Oyserman, 2012). In sum, self-ascribed identity not only informs but persuades certain behaviors. Moreover, even with the behavioral competence, capacity and autonomy to do otherwise, individuals are prone to perform only those behaviors, however detrimental or unbeneficial, that feel most congruent to their primed and chosen racial or gender identity.

Self-ascribed identity has also been found to affect perception. Literature shows people's appraisal of their own perceived wellbeing and mental health can be moderated by self- ascribed social identities. Black Americans, when race was primed and self-ascribed, were more likely to feel disrespected, devalued and discriminated against (Alegria et al. 2011; Hausmann, Kwoh, Hannon, & Ibrahim, 2013). St. Claire and He (2009) found in their study of older adults ages 50 and older that those who self-identified as "elderly person" were more likely to view themselves with greater hearing loss and in more need of hearing aids than those who did not self-identify, even when objective measures of hearing acuity did not support the claims. Similar results have also been found in subsequent studies with asthma and cold sufferers, who when they self-ascribed as such, had a greater perceived need for treatment intervention/devices (e.g. inhalers, cold tablets), again even when perceptions did not corroborate diagnostic measures (St. Clair, Clift, & Dumbelton, 2008).

Positively, self-ascribed social identity can be particularly redeeming for those who are marginalized and disadvantaged. Through group self-ascription, marginalized individuals can develop a "shared" social identity with similar others, which has been found to compensate for lack of social support and capital (Haslam, Jetten, Postmes, Haslam, 2009). In a simulated

prison study, Haslam and Reicher (2012) found participants assigned to the subordinate role of prisoner were more likely to self-ascribe to the “prisoner” label, than those assigned to the “guard” role. Additionally, “prisoners” developed a sense of shared social identity and collectively resisted the stressors they faced, while “guards” failed to develop a sense of shared identity consequently experiencing failure as a group and overall decline in wellbeing. The shared identity associated with self-ascribed social identity “underpins the capacity for members of disadvantaged groups to work together to buffer themselves from the negative consequences of their circumstances” (Haslam et al., 2009, p. 1).

While as a singular construct, self-ascribed social identity has been found to induce certain behaviors and perceptions, there is an increasing scholarly focus on the confluent role of multiple self-ascribed and marginal social identities in the lived experience of people (Bowleg, 2013; Purdie –Vaughn & Eibach, 2008). Due to the differing and sometimes conflicting expectations and demands of many social identities, researchers suggest a distinctively oppressive and more onerous experience for those ascribing to two or more intersecting and subordinate identities. For example, those who self-ascribed to being “elderly” *and* “HIV-positive” reported greater tendency towards a devalued sense of self and self-stigma, than those singularly ascribed, especially if participants believed elderly people should not have HIV (Emlet, 2006). For these individuals self-ascription to multiple subordinate identities (elderly and HIV status) led to identity related discrepancies, resulting in further marginalization. Even when identity congruence can be found between two or more self-ascribed identities, an increase in risk taking and unhealthy behavior can ensue (Bowleg, 2013). Young Black men who had sex with other men, were more likely to take part in more high risk sexual behavior (e.g. no condom use) when they perceived doing so was both masculine (e.g. thuggish, not feminine) (gender-

identity congruent) *and* not overtly linked to the white culture (race-identity congruent) (Fields, Bogart, Smith, Malebranch, Ellen, & Schuster, 2012). In sum, congruence between expectations for ascribed social identities is important and may reveal not only the view people have of themselves, but the risks they are willing to take to accommodate multiple ascribed group expectations.

### **Illness Identity**

In the area of clinical research and mental health treatment, the impact of the experience and diagnosis of mental illness on one's identity has resulted in an increased interest in the notion of "illness identity". Yanos, Roe, and Lysaker (2010, p. 75) define "illness identity" as

"the social categories that a person uses to describe him or herself...as well as the social categories that others use to describe that person. [It is] the set of roles and attitudes that a person has developed about him or herself in relation to his or her understanding of mental illness and the affect from both the experience of objective aspects of illness as well as from how each individual person makes meaning of the illness."

Yanos et. al (2010) found in their studies of individuals in treatment for behavior and mental disorders that recovery and an overall sense of hope and self-esteem was moderated in psychiatric patients by the naming and meaning attached to their psychiatric condition. They argue that an assessment of any kind should include and account for how individuals characterize their diagnosed illness.

Self-identifying with an "illness" identity label can have varied implications for the person who chooses to do so. On the one hand, self-identifying may be a constructive "first

step” in symptom elimination recovery, the initial indicator of problem recognition and treatment investment. With many clinical treatment programs using the disease model as the dominant metaphor to conceptualize behavioral and mental disorders and inform treatment strategy and delivery, patients who self-ascribe to illness identity labels have been found to be better investors in their treatment and better able to mark more clearly the area of concern and process for intervention (Hirschman, 1992). In social support groups requesting self-ascription to a certain mental illness (e.g. bipolar disorder, autism, alcoholism), participants who self-ascribed to diagnostic social identity labels have shown a greater capacity to cope with the stigma of their condition and reject the negative stereotypes that others hold of them. In her qualitative studies of clinical de-labeling, Howard (2006) found diagnostic self-labeling was an important component to overall recovery for those in treatment. Those in treatment who self-identified with their diagnostic label experienced less “intrapsychic disorder” and a greater “sense of personal coherence” (Howard, 2006). Self-identification with the diagnostic/clinical label “provided a way to make sense of something that had felt like a nebulous or amorphous condition” (Howard, 2006, p. 308).

On the other hand, research has found socially constructed labels indicating mental illness, such as schizophrenia, drug and alcohol dependence, and mood disorder have been found to be pejorative in nature, evoking negative stereotypes of deficiency, culpability, and danger (Crisp, Gelder, Goddard, & Meltzer, 2005). Because of these external perceptions and stigma, research has shown self-ascription to clinical identity labels can lead to self-stigma and notions of deviance and can ultimately serve to undermine a person’s self-esteem and reports of wellbeing (Corrigan, Watson, & Barr, 2006; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). Self-ascribing to stigmatizing mental health identity labels may encourage one to claim

possession of the traits and interpret one's behavior and experiences as indicative of the traits (Johnson & Tiegel, 1991). Such beliefs have been associated with low self-image, pessimistic expectancies, prolonged negative self-attributions (Moses, 2009; Peterson & Seligman, 1993), depression (Link, 2001) and low self-esteem (Fife & Wright 2000). In his review focused on addiction and identity, Walters (1989) found that identification with an addictive activity may lead to increased involvement in that activity because the concept of identity serves a powerful motivational role.

Along with exploring how multiple social and marginal identities impact behavior and perception, progressively more research has begun to explore the conditions and/or circumstances under which individuals may self-ascribe to potentially pejorative and deviant social identity labels (Chiricos, Barrick, Bales, & Bontrager, 2007; Bernburg & Krohn, 2003). Some scholars have explained self-ascription to potentially negative and marginalizing identity labels as a function of social vulnerability and disconnection from conventional social ties and settings (Sampson & Laub, 1997; Scheff, 2009; Sherman, Smith, Schmidt, & Rogan, 1992; Thoits, 1995). They posit when social resources are limited and weak socioeconomic ties exist, individuals are more prone, due to their social vulnerability, to accept deviant identity labels. Young teen mothers, older virgins, and older undergraduates were all more willing to self-label as deviant, when they considered themselves to have limited social ties and to be socially sanctioned for violating age based norms (Bozick, 2006; Moses, 2009; Norris, 2011). Conversely, other scholars propose that strong social bonds, including marriage and employment, insulate from the potential negative effects of self-labeling because they have other social resources that overcome the impact of labeling (Moses, 2009). Higher social structural locations have greater social resources to combat the ill effects of stigmatization. An example of



this social structural influence can be found in a study of men released from prison, wherein White men were found to be less secretive and more willing to self-ascribe as an “ex-convict” than Black men (Winnick & Bodkin, 2009).

With race and gender identity having been found to play key roles in Black men’s decision-making and behaviors, it would make sense that Black men in treatment for behavioral and psychological disorders must also consider identities associated with mental illness and pathology. In studies assessing the link between addiction and identity, few have used all Black male samples and most, if not all, have been cross-sectional, rather than longitudinal, in design (Attie & Brooks-Gunn, 1989). Thus far, little is known about marginalized Black men’s receptivity to “illness” identity labels and the predictive and consequential variables associated with the personal decision to self-identify with clinical, yet potentially more marginalizing identity labels while in a treatment setting. It appears clinical self-labeling can have both negative and positive consequences, but little is known about the relative importance of these negative and positive consequences of identity choice on Black men in treatment settings. The mixed treatment and recovery outcomes of individuals treated for severe mental illness and behavioral disorders have generated efforts to identify variables related to positive outcomes and recovery (Yanos et al., 2010). However, essential questions for the mental health field continue to be how and why progress varies between individuals and how service systems can facilitate the potential for recovery (Yanos, et al., 2010). The few studies that have explored clinical label ascription and illness identity have failed to focus on intragroup differences of marginalized Black men in treatment. Much more is needed in understanding the processes that lead to illness self-identity and how illness self-identification triggers relate to specific negative and/or positive reactions. This study seeks to provide information that can help with an improved understanding

the role of “Choice” for marginal Black men in deciding whether to self-ascribe to the clinical identity label of “addict/alcoholic”, the indicators that predict self-ascription, and the relationship self-ascription has to treatment compliance, risk taking behaviors, and overall personal satisfaction.

### **Hypotheses**

This study uses survey data to examine the variability of self-identifying with an illness identity label within an all-Black male sample. In regards to inclination towards illness “addict/alcoholic” self-identification the following hypotheses are presented:

- 1) Within this all Black male sample, variability will exist in the inclination towards illness “addict/alcoholic” self-ascription, with the tendency for most to self-ascribe as “addict/alcoholic”.
- 2) An illness “addict/alcoholic” self-ascription will be related to the reported frequency and quantity of alcohol and other drugs use (i.e., the higher the reported drug use /frequency, the more likely participants will self-ascribe to the “addict” identity label).
- 3) Self-ascription to the illness “addict/alcoholic” identity label will be associated with distinctive within-group demographics (e.g. age, education, economics, relationship/partner status, prior treatment history, drug use history).
- 4) Self-ascription to the illness “addict/alcoholic” identity label will be negatively associated with satisfaction/social adjustment measures. Those who report satisfaction in communication, leisure, role, sexuality, financial, and friends/relatives will be less likely to ascribe to illness “addict/alcoholic” identity label.
- 5) Those with high perceived control/mastery will be less likely to ascribe to the illness “addict/alcoholic” identity label.

With regard to assessing the impact of ascribing to the “addict” identity on treatment compliance, risk-taking behavior and overall psychological wellbeing, the following hypotheses are offered:

- 1) Ascribing to the illness “addict/alcoholic” identity label will positively predict help receptivity, problem recognition, and active recovery.
- 2) Ascribing to the illness “addict/alcoholic” identity label will more likely predict reports and admittance to more risk taking behaviors/ indicators.
- 3) Ascribing to an illness “addict/alcoholic” identity label will be negatively associated with personal wellbeing measures.

## **Methods**

This comparative study utilizes results from the JEMADARI study, a longitudinal study conducted over a five year period (2001 to 2006) in Detroit, Michigan (Gant, 2013). The original intent of the study was to test the efficacy of a culturally specific HIV/AIDS risk reduction intervention program for Black men receiving inpatient substance abuse treatment in urban settings (Gant, 2013). The JEMADARI Study recruited over a two year period (May 2003 through August 2005) twelve cohorts of Black men from six separate residential substance abuse treatment programs in Detroit, Michigan. Participants resided at these facilities, apart from their families and the community for an extended period of time.

The present study is a secondary analysis of the first of three waves of the JEMADARI data. It assesses two discrete groups: self-ascribed “addict/alcoholic” (SA) or non-self-ascribed addict/alcoholic (NSA). Members of the SA group are those who responded with either a

“somewhat agree” or “strongly agree” to the survey question, “I am an alcohol/drug addict.” All analyses were conducted using SPSS version 20.0. First, demographic characteristics were calculated. Logistic regression models were performed to examine the predictive value of illness “addict/alcoholic” self- ascription to treatment compliance, risk taking behaviors and overall wellbeing measure.

### **Participants:**

Table 1-1 provides a number of descriptive characteristics of the overall sample of men participating in this study. In sum, four hundred and seventy one Black men ages 19 to 71 (with a mean age of 43) completed the initial survey. At the time of the study, all study respondents were admitted and current participants in residential treatment for drug addictions and substance use disorders at various sites in Detroit, Michigan. Seventy-four percent had had previous treatment and only thirty six percent held jobs prior to treatment. Only thirty percent had completed high school. Fifty-five percent received health insurance through public assistance and approximately twenty percent were homeless (Gant, 2013).

### **Procedures:**

Individuals participated in the study voluntarily and were provided no compensation or incentives to participate. Participants attended initially an orientation, where they completed consent forms, provided personal contact information, and completed a computer-based questionnaire, which included questions about demographics, substance abuse and treatment history, sexual history, perception of treatment needs, social/relational support, and racial/social barriers.

Participants were given the computer-based questionnaire on two separate occasions following their participation in the residential treatment program. The first post-test session occurred thirty days following treatment participation and the second post-test session occurred six months following treatment participation.

**Measures:**

*Self-labeling status variable:* To assess self-ascription to the illness “addict/alcoholic” identity label, participants were asked whether they agree or disagree with the following statement, “I am an alcohol/drug addict.” Responses could range from 1 (strongly agree) to 5 (strongly disagree). Those who agreed (strongly or somewhat) with the statement were identified as self-ascribed addicts/alcoholics (SA) participants, while those who responded with negative or no response were considered non-self-ascribed (NSA) participants.

*Socio Demographic variables:*

- 1) Age: Based on reported ages, the sample was divided into three categories: young adult (19 to 40), middle adult (40 to 64), and late adult (65 and older)
- 2) Education: Participants’ responses were classified using five categories: “elementary/some high school,” “High School Completed,” “Trade/Technical School”, “Some College”, “College/Graduate School Completed”.
- 3) Employment status: Employment status was assessed by the following two questions: “Were you employed prior to treatment?” and “Have you ever been employed?” Respondents were considered unemployed and never employed if responses were negative to both questions.

4) Relationship/Partner status: determined by the following survey questions  
“Are you currently in an intimate relationship?”

5) Prior Drug Use History: Determined by several selected questions: (e.g.  
“Have you ever consumed alcohol?”, “Have you ever used marijuana?”, “cocaine?”, or  
“heroin?”)

***Treatment Investment/Response Variables:*** To measure treatment response and investment, the *Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)* was used.

SOCRATES is an experimental instrument designed to assess readiness for change and treatment investment in alcohol/drug abusers (Miller & Tonigan, 1996). The instrument traditionally yields three factorially-derived scores: Recognition, Ambivalence, and Taking Steps (Miller & Tonigan, 1996). However, for the purpose of this study, only scores from two (Recognition and Taking Steps) of the three subcategories were used. Also, for the purpose of this study only, the Recognition category was renamed to Help Receptivity/Problem Recognition and the “Taking Steps” category was renamed “Active Recovery”.

1) Help receptivity/Problem recognition: The following selected questions were used to assess this variable: “*I really want to make changes in my drinking/drug use.*”, “*If I don’t change my drinking/drugging soon, my problems are going to get worse.*”, “*I have a serious problem with drinking/drugs.*”; “*My drinking is causing a lot of harm.*”, “*I know that I have a drinking problem.*”; and “*I want help to keep from going back to the drinking/drugging problem that I had before.*” Utilizing the selected questions, the current study rendered a Cronback alpha coefficient of .94.

2) Active Recovery: The following selected questions were used to assess this variable: “*I have started making some changes in my drinking/drug use*”; “*I’ve managed to change*

*my drinking/drug use; “I have made some changes in my drinking/drug use; “I have already changed my drinker/using; “I am actively doing things now to cut down or stop drinking/using; ; and “I am working hard to change my drinking/drug use”*. Utilizing the selected questions, the current study rendered a Cronback alpha coefficient of .86.

***Drug Use Decrease variable:*** To assess this variable the following selected question from the JEMADARI study was used to assess this variable: *“Have you tried to decrease your use of alcohol and/or other illicit drugs?”*

***Overall Satisfaction/Wellbeing variable:*** The following selected question from JEMADARI questionnaire was used to determine this variable: *“How satisfied are you overall?”*

***Social Satisfaction variable measure:*** The following selected questions were used from the JEMADARI questionnaire to determine perceived satisfaction in varied aspects of participant’s lived experience:

Communication satisfaction: *“How satisfied are you with communication and openness in your relationships?”*

Sexual Affection/Care satisfaction: *“How satisfied are you with sexual affection and care in your relationships?”*

Financial satisfaction: *“How satisfied are you with your finances?”*

Role satisfaction: *“How satisfied are you with your role in relationships?”*

Leisure/recreational satisfaction: *“How satisfied are you with recreational activities and leisure time?”*

Friend/relative relationship satisfaction: *“How satisfied are you with your relationship with friends and relatives”?*

Responses could range from 1 to 5 with scores representing the following: 1 (strongly agree), 2 (agree), 3 (undecided/unsure), 4 (disagree), and 5 (strongly disagree). For the purposes of this study and to ensure the absolute assessment of satisfaction in these areas, the scores were collapsed to render two discrete categorical variables for each question, with (1) representing those reporting “very satisfied” and “satisfied” and (0) representing all other responses.

***Perceived Control variable:*** This variable was measured by utilizing an adapted version of the 12 item John Henryism Active Coping Scale (JHAC12) (James, 1994) (see Appendix A). Each item response was measured on a 5 point Likert scale, with scores representing the following: 1 (strongly agree), 2 (agree), 3 (undecided/unsure), 4 (disagree), and 5 (strongly disagree). Scores were gathered by summing up the 12 items responses for each respondent, with possible scores ranging from 12 to 60. The resulting scores were then collapsed into two discrete categories with 1 representing high perceived control/John Henryism participants, who succinctly and affirmatively responded to all of the JHAC 12 questions with either a 1 (strongly agree) or 2 (agree). All others were categorized as “0” and not high in perceived control/John Henryism.

While maintaining the integrity of the measure and with the permission of the scale’s designer, the originators of the JEMADARI study chose to modify three of the JHAC12 questions to make them more adaptable to the sample population (Gant, 2013). For example, one of the original scale measure questions read, *“When things don’t go the way I want them to that makes me work even harder.”* The JEMADARI study revised the sentence to read, *“When things don't go the way I want them to that just makes me work even harder.”* A second original question from the JHAC12 measure read, *“Very seldom have I been disappointed with the results*



of my work.” The JEMADARI study altered the sentence to read, “*Very seldom have I been disappointed by the results of my hard work.*” Lastly, a third JHAC12 original question read, “*I feel that I am the kind of individual who stands up for what he believes in, regardless of the consequences*” was changed to read, “*I am the kind of person who stands up for what I believe in regardless of the consequences*”. Reliability analyses show a scale with good internal consistency, yielding an overall Cronbach alpha coefficient of .89

**Analysis:** All analyses were conducted using SPSS version 20.0. Sociodemographic variables were statistically compared to assess for significant association with illness “addict/alcoholic” self-ascription utilizing,  $\chi^2$  test and an independent samples t tests. Finally, simple logistic regression models were performed to examine 1) whether satisfaction measures were predictive of self-ascription to the “addict” label, and 2) if “addict” self-ascription is predictive of reported treatment compliance, other risk taking behaviors, and overall reports of personal satisfaction.

## **Results**

### ***Addict Self Labeling/Ascription Inclination***

To assess “addict” self-ascription, participants were asked if they agree or disagree with the following statement about their drinking and other drug use patterns, “*I am an alcohol/drug addict*”. As shown in Figure 4, half of the participants 242 (51.4%) subscribed to the label of addict, while the remaining 229 (48.6%) rejected the addict label. A chi-square test for goodness of fit was performed to explore if the proportion of cases within the self-ascribed and non-self-ascribed categories were significantly different in distribution. The results revealed no significant difference in proportion,  $\chi^2$  (1, N=471)=>359,  $p<.55$

Additional chi square tests were completed to see if self-ascribed addicts and non-self-ascribed addicts were distributed differently across other selected demographic characteristics. As indicated in Table 2-1, none of the selected demographics (e.g. age, education, previous employment, previous treatment involvement, or legal coercion) indicated a significant relationship with self-ascription to the addict label.

Utilizing an independent samples t –test to compare the relationship of the frequency and type of drug use reported, there was a significant difference in the number of drinks consumed on average for those who self-ascribed ( $M=4.47$ ,  $SD=3.53$ ) and those who did not self-ascribed ( $M=5.35$ ,  $SD=3.53$ );  $t(369) = 2.403$ ,  $p = .02$  (two tailed), with more drinks reported by those who did not self-identify as “addict/alcoholic” than those who did. The magnitude of the difference between the means (mean difference = .88, 95% CI: .16 to 1.608) was small (eta squared = .015). Even so, the reported difference resulted in a significant decreased tendency towards illness “addict/alcoholic” self-ascription as the rate of reported use increased.

### **Self-Labeling Predictors**

Since the dependent measure of “addict/alcoholic” self-ascription was discrete, direct logistic regression was performed to estimate the influence of a number of factors on participant’s likelihood to self-identify as an “addict/alcoholic”. The model contained eight independent variables: a current partner relationship status measure, a perceived control measure, and six measures assessing various states of social/relational satisfaction (e.g. communication satisfaction, financial satisfaction, sexual satisfaction, leisure satisfaction, friend satisfaction, and role satisfaction). The full model containing all predictors was statistically significant  $\chi^2(8, N=471) = 200.007$   $p < .001$ , indicating that the model was able to distinguish between respondents who self-label as addict and those who did not. The model as a whole explained between 34.6%

(Cox & Snell R-Square) and 46.1% (Naglekerke R Squared) of the variance in self-ascription and correctly classified 73.9% of the cases. With the elimination of the demographic “current relationship” variable, the model explained between 50.7% and 67.8% of the variance in self-ascription and correctly classified 85.5% of the cases.

As shown in Table 2.2, only four of the independent variables made a unique and statistically significant contribution to the model: current relationship status, financial satisfaction, sexual satisfaction, and high perceived control. The strongest predictors of self-ascription were financial satisfaction, recording an odds ratio of 16.79 and current intimate partner relationship status, recording an odds ratio of 9.78. This indicated that, controlling for all other factors in the model, the respondents who reported satisfaction with their finances were over 16 times more likely to self-ascribe to the illness identity label than those who did not report financial satisfaction, and were over 9 times more likely to report as an “addict/alcoholic” if in a current intimate partner relationship than those who were not. The odds ratio of .79 for perceived control and .04 for sexual satisfaction were less than 1, indicating that for every indication of perceived control and sexual satisfaction respondents were significantly .79 and .04 times less likely to self-ascribe, controlling for other factors in the model. Interestingly, in this model the constant--the expected value of the log-odds of addict self-ascription when all of the predictor variables equal zero--was significant. With a Wald statistic equal to 50.267 [df=1], results revealed a odds ratio of 426.008, which was significant at the .01 level. This result indicated that if all cases reported no perceived control, no current relationship and dissatisfaction in the social variables given in the model, the likelihood of “addict/alcoholic ” self-ascription is over 400 times more likely to occur than not.

### **Self-Labeling and Treatment Receptive/Compliance**

A simple logistic regression was performed to assess the predictive value of addict self-identification on two separate components of treatment compliance/receptiveness: Help Receptivity/Problem Recognition and Active Recovery. Results reveal (see Table 2-3) that self-identifying as an addict is strongly predictive of Help Receptivity/Problem Recognition. The full model containing the predictor of “addict/alcoholic” self-ascription was statistically significant,  $\chi^2(1, N=471)=433.83, p<.001$ , indicating that the model was able to distinguish between respondents who reported positive for Help Receptivity/Problem Recognition and those who did not. The model as a whole explained between 58.1% (Cox and Snell R square) and 77.7% (Nagelkerke R squared) of the variance in Help Receptivity/Problem Recognition reports and correctly classified 92.6% of the cases. “Addict/alcoholic” self-ascription made a significant contribution, recording an odds ratio of 207.89 indicating that those who self-ascribe to the addict label were over 200 times more likely to indicate receptivity to help and recognition of problems related to their substance use than those who do not ascribe to the illness “addict/alcoholic” identity label.

In regards to Active Recovery, addict/alcoholic self-ascription was conversely significant. With a statistically significant model explaining 57.7% to 77.7% of the variance for Active Recovery, addict self-ascription decreased the likelihood of reporting active recovery reporting. With an odds ratio of .005, those who self-ascribed as addicts were significantly less likely to engage in active recovery.

### **Risk Taking Behavior**

Simple logistic regression was performed to assess the impact of illness “addict/alcoholic” self-ascription on risk taking behavior, namely HIV testing, condom use and sexual partners. The full model containing the independent variable of self-ascription was

statistically significant, indicating the model used was able to distinguish between respondents who self-ascribed and those who did not. As shown in table 2-3, addict self-ascription made a statistically significant and negative contribution to HIV testing, recording an odds ratio of .527, less than 1 indicating that for every positive report of self-ascription respondent are .527 less likely to complete HIV testing. Addict self-ascription, however, was not a significant contributor to the number of sexual partners reported or condom use frequency.

### **Overall Satisfaction And Wellbeing**

As indicated in Table 2-3, the regression results indicate that reports of overall wellbeing and satisfaction were directly in accordance with how a person self-ascribed. Illness “addict/alcoholic” self-ascription remained a significant contributor to the decreased likelihood of reporting overall wellbeing and satisfaction. Those who self-ascribed with the illness “addict/alcoholic” label were less likely to report positive overall wellbeing. The odds ratio of .243 indicates those who self-ascribe as addicts were significantly less likely to report wellbeing. The coefficient on the self-ascription variable has a Wald statistic equal to 19.40 which is significant at the .01 level (95% confidence level) with a critical value of 29.087 [df=7]. The overall model is significant at the .01 level according to the Model chi-square statistic.

### **Discussion**

Utilizing an all Black male sample of individuals participating in substance abuse treatment, this study examined intragroup differences pertaining to self-ascribed social identity, by assessing the factors associated with illness “addict/alcoholic” self-ascription and the

consequential ramifications related to this self-ascription. Five hypotheses were tested related to self-ascription inclination and three broad hypotheses were tested related to the associated consequences of “addict/alcoholic” self-ascription. Given the participants’ self-reported history of extensive drug use and prior substance abuse treatment, the first hypothesis posited that intragroup differences would exist, with a tendency towards “alcoholic/addict” self-ascription. As predicted, a slight majority of the sample self-ascribed to the “addict/alcoholic” label.

However, in regards to the second hypothesis stating that “addict” self-ascription would be significantly associated with distinctive within-group demographics, this study showed primarily no significant differences or trends in the demographical areas of age, education, prior employment status, and prior treatment history. While there were a few more Black men “addict/alcoholic” self-ascribers who reported they were in current relationships than those who did not self-ascribe, the difference was not considered significant. In sum the Black men in this study were, for the most part, equally represented demographically in both self-ascribed (SA) and non-self-ascribed (NSA) group categories. Self-ascription’s insignificant association with selected demographic variables may be explained in part by the lessening effects of these factors when assessing within group differences of individuals similarly marginalized.

It was further hypothesized that there would be a significant and positive correlation between frequency and quantity of use and “addict/alcoholic” self-ascription. While the results of the study revealed a significant association between frequency and quantity of alcohol use per event, the results did not reveal a statistically positive association as expected. In fact, men who reported relatively higher levels and frequency of alcohol and drug use were less likely to self-identify with the illness “alcoholic/addict” identity label. Similar trends, though insignificant, were found with reported marijuana and cocaine use. Interestingly, with drug addiction by

formal definition being characterized by high use occurrence in frequency and amount, the study's sample countered this notion by showing an increased willingness to characterize their use as "addict/alcoholic" when use was relatively less rather than more. This is important in that it perhaps offers insight as to the thinking of certain marginalized men in treatment, who with their admittance to extreme and thus flawed drug use behavior may be resisting further marginalization through the rejection of the uncomplimentary "addict/alcoholic" identity label. Marginal Black men may tend to reject the utilization of certain official clinical identity labels as they reveal more details about the symptoms of their illness (e.g. degree of use and consumption) and this acknowledgment alone may be sufficient enough to intervene therapeutically.

Along with the aforementioned demographic variables, social, relational and perceived control variables were hypothesized to be predictive of "addict/alcoholic" group self-ascription. The results provided mixed results, only partly supporting the hypothesis, since not all selected relational variables were influential. The results revealed relationship status, perceived control, financial satisfaction, and sexual satisfaction were the primary predictor variables in the statistical model used. Participants reporting sexual satisfaction and high perceived control were significantly less likely to ascribe to addict/alcoholic identity label. Understandably so, those with an elevated sense of personal mastery and/or perceived control and high sexual/intimate care satisfaction presumably had a much more efficacious view of their capacity and personal functioning and thus seemed less likely to identify with identity labels that communicate dependency and unmanageability. On the other hand, financial satisfaction and being in a current relationship significantly increased the odds of participants' willingness to ascribe to the illness "addict/alcoholic" identity label. In this case, partnership and economic satisfaction seem to buffer against the potential stigma of self-identifying as an "addict/alcoholic". This result

seems to support other research that people are more willing to face difficulty and self-identify with deviant labels when they have satisfactory social support and stability (Moses, 2009). In sum, it appears self-ascription to the “addict/alcoholic” identity is a function of one’s perceived status and satisfaction in social areas of life, specifically current partnership, power, money and sexual/intimate care, and not based on official and clinically-delineated symptoms associated with “addict/alcoholic” label.

In regards to treatment compliance, it was hypothesized that addict/alcoholic self-ascription would positively predict help receptivity/problem recognition and active recovery. This was partly supported, in that self-ascription was significantly predictive of high help receptivity/problem recognition. However, while those inclined towards illness “addict/alcoholic” self-ascription were more likely to report wanting helping to prevent relapse in drug use, they were less likely to report active engagement (or initiative) in behaviors to reduce and/or abstain from further drinking/drug use behavior. Additionally, self-ascription was significantly related to the reduced likelihood to report problems with alcohol or drug use. Perhaps these seeming odd findings might be explained by the sample’s incremental willingness to reveal vulnerability and need. Perhaps, reporting problem recognition is dissuaded by the social vulnerability of the sample’s choice to self-ascribe to the “addict/alcoholic” identity label and their expressed willingness to receive help. Furthermore, the results reveal self-ascribed individuals were resigned to a more passive acceptance of help if given or offered, but less willing to initiate or pursue steps to reduce their problem use. In sum, illness “addict/alcoholic” self-ascription seems to be predictive of a certain treatment dependency, with non-self-ascribers showing greater treatment agency and independence.



This study hypothesized that self-ascription would predict a greater tendency toward high risk behaviors. Those who self-ascribed as “addict/alcoholic” were less likely to take HIV tests, again to initiate responsibility for their self-care and personal health. However, there were no other significant risk taking behaviors associated with ascribing to illness “addict/alcoholic” label, which contradict some studies that indicate subscription to a potentially pejorative label makes one more vulnerable to engage in further deviant and risk-taking behavior (Bowleg, 2013).

Finally, it was hypothesized that addict/alcoholic self-ascription would be negatively associated with personal wellbeing measures. The results support this conclusion. Not self-identifying with the illness “addict/alcoholic” label was significantly predictive of reported overall wellbeing. Self-identifying with “addict/alcoholic” identity label may be an indicator of weakened perceived status personally and a certain sense of powerlessness or inefficacy, thus resulting diminished personal satisfaction and happiness. Literature supports the notion that a positive perception of social support and oneself is important and instrumental to long term treatment compliance (Sung, 2005).

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## **CHAPTER III**

### **MARGINALIZED COGNITION:**

#### **Perceived Control and Gendered Responses among Black Men In Treatment**

##### **Abstract**

Perceived control is a belief in one's personal power or ability to affect change and make a difference in one's life's circumstances. Most believe they have it and few deny its benefits. Yet, few studies have examined perceived control's reported presence and effects among multiply marginalized men while in treatment. Utilizing a cultural measure of perceived control and active coping known as John Henryism, this study examined the differential effects of selected demographic factors and other dispositional satisfaction states on the reported perceived control beliefs of 471 Black men in substance abuse treatment. Purported as a representation of a type or aspect of black masculinity, this study also further assessed perceived control beliefs predictive relationship to help receptivity, active recovery, drug use behavior, and reported overall wellbeing. Results indicate intimate partner relationship status, sexual/intimate care satisfaction and role satisfaction measure were predictive of perceive control/John Henryism. Subsequently, perceived control/John Henryism was found to be positively related to active recovery and overall wellbeing, but negatively predictive of help-receptivity.



## **Introduction**

For Black men with substance use disorders in residential treatment, the marginalizing circumstances resulting from the intersection of substance abuse, race, and social exclusion may lead some to a diminished sense of personal capacity and control, but not necessarily (Cole, Logan & Walker, 2011). The post-modern philosophy of social construction is grounded in the assumption that people gather information from their senses and cognitions and describe it in different ways resulting in a constructed truth, not objective truth (Raskin & Bridges, 2002). The implication here is that realities are formulated by the perceiver's perception. Perception is truth and truth is relative. People's perceptions become meaningful and "real" for them, even when the insistence of others and the definiteness of circumstances purport a different or "objective" truth (Raskin & Bridges, 2002).

This chapter explores the cognition of personal control, through the use of a measurement for John Henryism (James, 1994). While generally used as a measure of an active coping style, John Henryism is also a measure of perceived control, distinctly normed on a treatment sample of African-American men (James, 1994). This study examines the influence of selected sociodemographics and pre-existing affective relational states on the perceived control beliefs (John Henryism) of Black men with substance use disorders while in treatment and follows with an exploration of the subsequent effects of perceived control (John Henryism) beliefs on treatment receptiveness, reported drug use behavior, and overall satisfaction. Through this study we aim to learn more about the persistence of perceived control in marginalized men despite the circumstances that seem to oppose it.

## Related Theory and Research

### *Perceived Control*

Rooted in a strength-based philosophy, perceived control has been broadly defined as “the belief that one can determine one’s own internal states and behavior, influence one’s environment, and/ or bring about desired outcomes” (Wallston, Wallston, Smith, & Dobbins, 1987). Elsewhere it has been characterized as the perception that “you can and do master, control and shape your own life” (Ross & Mirowsky, 2013). This belief construct has received a fair amount of study in a number of social and behavioral sciences, where it has been referenced in a variety of ways and through a variety of theoretical terms and names such as mastery, personal autonomy self-efficacy, instrumentalism, agency, and self-reliance (Ross & Mirowsky, 2013; Ajzen, 2002; Kiecolt, Hughes & Keith, 2009). The lack of perceived control has been addressed through an assortment of terms such as learned helplessness, external locus of control and perceived powerlessness.<sup>3</sup> In sum, Ross & Mirowsky (2013, p. 380) explains

“Perceived control and powerlessness represent two ends of a continuum, with the belief that one can effectively alter the environment at one of the continuum, and the belief that one’s action cannot influence events and circumstances at the other”

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<sup>3</sup> This dissertation does not assume these terms are measuring the same thing, although they are often used interchangeably in literature. Many of these terms are quite similar in that they are concerned with a person’s perceived ability to perform a behavior. However, some have cautioned against the interchangeability of these terms used to reference perceived control, because they are measuring different components of the same concept (Ajzen, 2002). For example, some have argued, that some perceived control beliefs terms measure a person’s belief about his or her control or capacity to express or enact certain behaviors (e.g. self-efficacy), while other perceived control belief terms measure personal beliefs about control over the expected outcome and events resulting from his/her enacted behaviors (e.g. locus of control). It is presumed that the measure of perceived used for this dissertation study (e.g. John Henryism) addresses and measures both.

Literature supports that people are motivated to seek and achieve perceive control and a large majority in the US report they have it (Dupuis et. al, 2012; Ross & Mirowsky, 2013). High perceived control beliefs has been found to have a powerful influence on personal well-being and functioning (Mirowsky & Ross, 2003; Skinner, 1996), and is posited as the most successful “self-belief” in dealing with stress, crises and ostracism (Keicolt & Hughes,2009; Pearlin, 1999) because perceived control seems to assist in helping people assess their stressors as less threatening.

When perceived control is present and pronounced, studies show that it can positively impact emotional well-being. When people appraised themselves high in personal control they were less likely to experience feelings of helplessness and passivity (Skinner, 1996). High perceived control contributed to emotional improvement for those with mood and affective disorders (Mirowsky & Ross, 1989; Watkins, Hudson, Caldwell, Siefert & Jackson, 2011) and increased reports of happiness and less sadness or depression (Chapman, Skinner, & Baltes, 1990; Mirowsky & Ross, 2003; Watkins et al., 2011). For example, in a study of Black men, Watkins et al’s (2011) found that perceived control, under the name of mastery, was protective against depressive symptoms regardless of life stage and age. Mirowsky and Ross (2003) found a negative correlation with unhappiness and dissatisfaction and perceived control among those suffering with mental illness. In sum, when individuals begin with emotional distress, an increased perceived control seems to be instrumental in improving one’s overall affect.

Literature reveals perceived control not only impacts mood and affect, it influences coping behavior and performance (Peterson & Stunkard, 1989; Ross & Mirowsky, 2003). Specifically, high perceived control is correlated to high motivation and perseverance (Kieicolt, & Hughes, 2009; Peterson & Stunkard, 1989). The more a person perceives control in a

situation, the more he is likely to engage in the focused behavior (Ajzen, 2002). People with high perceived control were more likely to consider and attempt multiple alternatives and strategies, when their initial repertoire of behaviors did not work (Wallston, 1994; Ross & Mirowsky, 2003). The strength of perceived control has been found to correlate with reports of abstinence from addictive behaviors, such as eating disorders and alcohol consumption (Krentzman, 2013; O’leary, 1985). It appears that a higher sense of control fosters an active, problem focused coping style (Kiecolt & Hughes, 2009; Thompson & Spacapan, 1991), facilitates the ability to better cope with stressful events, and buffers against the aversive effects of difficult situations (Kiecolt & Hughes, 2009). In sum, perceived control enables successful behavior achievement, which in turn enhances perceived control the more.

While the vast majority of the literature supports the benefits of perceived control, some literature suggest this is not the case under certain conditions. For example, some research has found a “threshold of dysfunction” wherein the level of perceived control reverts from reducing psychological distress to increasing it under certain circumstances (Mirowsky and Ross, 1990; Kiecolt & Hughes, 2009). Mirowsky and Ross (1990) in their study of persons with mental health problems found those who had the resources to support their goals benefited by far more than those whose personal resources (e.g. family, financial) were limited. Neighbors, Njai and Jackson (2007) found high perceived control, utilizing a measure of John Henryism, was counterproductive physiologically and psychologically when individuals in the sample were depressed and incapacitated by a low socioeconomic and racial status. It is reasonable to expect people most vulnerable to having their personal control exacerbated by multiply marginalizing social conditions, structures, and statuses will express a lowered sense of personal control than those who are less marginalized. In their overview of perceived control studies, Mirowsky and

Ross (2013) identify five sociodemographic correlates associated with a diminished sense of personal control:

- 1) Socioeconomic status (i.e. unemployment, limited to no education, economic hardship)
- 2) Age-(i.e. older adults have lower perceived control than do younger adults)
- 3) Neighborhood context-(i.e. threatening environments, not characterized by peace, safety and observance of the law)
- 4) Race- (i.e. Blacks have lower average levels of control than Whites)
- 5) Gender- (i.e. women have lower control sense of control than men)

### ***Gender and Perceived Control***

In men's studies a prominent area of research is the assessment and influence of perceived control, namely in reference to power and self-reliance (Connell, 2005; Kimmel, 2000). Research has found that men engage in gendered responses in an effort to assert power and self-efficacy or to regain personal control (Addis & Mahalik, 2003; Courtenay, 2008; Dupuis, 2011) and specifically avoid behavior and circumstances that may reduce power or display weakness (Addis & Mahalik, 2003; Courtenay, 2010). Given the patriarchal stance of men in society, it would seem theoretically that men would on average be more likely to report high perceived control than women, and in several cases they do. (Mirowsky & Ross, 1983; Ross & Mirowsky, 2013; Thoits, 1987). However, other studies have found the differences in report of perceived control between men and women to be insignificant or conditioned on mediating factors (Ross & Mirowsky, 2013; Ross & Mirowsky, 1989). For example in a study of gender

differences in perceived control, differences disappeared when college educated women were compared with men of equivalent age but less education (Ross & Mirowsky, 1989). Higher educational status mediated the influence of gender.

Routinely confounding the simple analysis of men and their gendered behavior (e.g. masculinity) is the paradox that men can hold power objectively in society because of their gender through influential and powerful positions, but often report feeling powerless and expressing little ability to control and determine their life conditions (Courtenay, 2010; Mankowski & Maton, 2010). This discrepancy between objective power and subjective powerlessness has been identified as one of the damaging aspects of what has been described in literature as “traditional” masculine ideology (David & Brannon, 1976; Levant, 1992). While there are many masculine ideologies, the ideological construct of traditional masculinity prevalent in the US is a dominant, traditional form of masculinities typically characterized by anti-femininity, restricted emotions and a perpetual focus on the possession and maintenance of power, control and self-reliance (Kimmel, 2009; Connell, 2005).

Traditional masculine ideology’s notion of power and perceived control can be found in the social constructionist model of “hegemonic masculinity,” which, at the time of its development, became a popularly contrasting model to the pre-existing essentialist and social learning theory models of masculinity (Connell, 2005). The model presents four hierarchical layers of masculinity: dominant masculinity, complicit masculinity, marginalized masculinity and subordinated masculinity. Dominant masculinity refers to the idealized and socially expected ways of being a male (Connell, 2005), part of which is a display of strength and control as well as an emphasis on competition, wealth, aggressiveness, and heterosexuality. While all men are situated within a context that exposes, if not compels, them towards this dominant

masculinity, all are not able or at equal liberty to access the cultural and economic resources to fulfill the expectations. Connell's presentation of alternative layers of masculinities introduced the notion that masculinity was not a singular trait, but multiple. Moreover, these diverse and varied masculinities develop in partly because the dominant hegemonic form of masculinity cannot be enacted by individuals who lack the necessary resources (Connell, 2005).

Traditional (hegemonic) masculinity has been found to be associated with stress, poor health, and relationship problems (Courtenay, 2000). According to O'Neil, Helms, Gable, David, & Wrightsman's (1986) Gender Role Conflict Theory (GRC), men experience stress, even when successfully accomplishing socially sanctioned manhood, because of the contradiction between the demands of the male role and other naturally occurring desires. He described gender role as behaviors, expectations, and role sets defined by society as masculine and feminine, which are embodied in the behavior of the individual man or woman and culturally regarded as appropriate to males and females (O'Neil et al., 1986). According to O'Neil et al. (1986), gender role conflict occurs when men's inflexible adherence to restrictive gender role results in personal restriction, devaluation or violation of others or themselves. Conflict arises out of a fear of being associated with weakness and powerlessness and in response may find men compensating by engaging in unhealthy and risk-taking behavior (O'Neil, 2008). Much of the research about gender role conflict (GRC) focuses on the negative results of the male socialization process and a diminished sense of perceived control (O'Neil, Good & Holmes, 1995). Hayes and Mahalik (2000) found that men who have high scores on GRC scales report greater mental health problems, but are less likely to engage in professional help-seeking. These findings have primarily been completed on samples not primarily consisting of people of color.

### ***Black Men, Perceived Control, Masculinity, and John Henryism***

The historical and social constructions of race in the United States have influenced the meaning and identities associated with Black men and masculinity (Jackson II & Dangerfield, 2004). Scholars have asserted that Black men have a different set of socializing influences than White men and, as a result, define and express masculinity variously and differently (Boyd-Franklin, Franklin, & Toussaint, 2000). Some research has shown that Black men endorse traditional masculinity ideology to the same, if not stronger, degree than European American men (Levant & Majors, 1997; Levant, Smalley, Aupont, House, Richmond, & Noronha, 2007). Other studies have produced data that clearly differentiates Black men from traditional masculinity ideology (Hunter & Davis, 1994; Hammond, Banks & Mattis, 2006; Wade 2009). In examining Black men's perception of masculinity, several researchers have found that Black men endorse aspects of both traditional masculine roles (e.g. independence, aggressive, competitive, being a provider) and nontraditional masculine roles (e.g. emotional sensitivity, egalitarian family, humanism) (Hunter & Davis, 1994; Wizdom & Mattis, 2005).

Some scholars assert Black men are placed in a difficult and inherently disadvantage position in so far as the traditional definition of masculinity appears to exclude them (Cazenave, 1984; hooks, 2004; Majors, 2001). Some have argued that Black masculinity is a contradictory (and subordinated) form of identity, because historically Black men have been prevented from demonstrating aspects of patriarchy masculinity such as access to positions of power (Garfield, 2010; Mercer & Julien, 1994). Black men, subsequently, find themselves between honoring Afrocentric values while simultaneously trying to live up to the mainstream values of success, competitiveness, and aggression. The primary implication of these models is that Black males'



behaviors and sense of manhood are made deficient, if not deviant, by the racially restrictive and confining social structure and system.

Newer alternative approaches see masculinity as multiple and constructed by men in a variety of ways (Robertson, 1995). When it comes to Black men, John Henryism may certainly be an appropriate indicator of a version of Black masculinity, counted among many others. Normed and developed from a sample of lower-income African-American men in poor semirural area of North Carolina, John Henryism is arguably a cultural representation of a type or aspect of Black masculinity—a masculine script used by Black men<sup>4</sup>. According to Riska (2006, p. 135)

John Henry is a racialized construction of man... a type of Black masculinity that embodies the ethical codes of white middle-class America... striving hard to achieve the values and goals of the white world, but denied full access and full agency as a man in the social and political order of dominant white masculinity

It appears that whether Black men ascribe to a traditional masculine ideology or to a culturally form of masculine thinking and behaving or aspects of both, perceived control, in the name of self-reliance, independence, and personal achievement remain essential elements of masculine thinking among Black men. The various versions of Black masculinities all contribute to the understanding of how certain Black men construe the social context and subsequently respond. Most importantly, Black masculinities cannot be understood or suitably explained apart from the consideration of both race and gender. In other words, race is gendered and gender is raced (Flood, 1994).

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<sup>4</sup> It is important to note that given the target population of this dissertation, John Henryism is presented as a typology indicative of perceived control and a type of masculinity. However, it is important to note that John Henryism is not an exclusively gendered term and has been used to assess John Henryism in women as well (see Neighbors, Hudson & Bullard, 2012)

John Henryism is certainly an appropriate indicator of perceived control and the effects it has on personal wellbeing and behavioral outcomes of Black men. James (1994) developed the name and concept from the legendary John Henry, who was an uneducated, but physically strong former slave who worked as a steel driver building railroads. When his job was threatened by the mechanical steel drill, he competitively challenged the steel mill and won, but died from physical and emotional exhaustion afterwards (James, Hartnett, Kalsbeek, 1983). Although a synonym for an active problem focused coping style, John Henryism was originally defined by its inventor as “an individual self-perception that [one] can meet the demands of his environment through hard work and determination” (James, et al., 1983). Also, the John Henryism scale for Active Coping or the JHAC 12 developed to evaluate the presence of John Henryism emphasizes three themes: “efficacious mental and physical vigor, a commitment to hard work; and a single-minded determination to achieve one’s goals” (James et al, 1983), all of which define the concepts of perceived control and notions of masculinity.

Many measures do not consider the unique life situations, experiences and histories of Blacks men, and are thus unable to capture the culture-specific strategies characteristic of Blacks men. As a result, in exploratory fashion, we examine John Henryism displayed in the context of treatment and how this display, in turn, influences perception of treatment. Given the number of studies that have shown the negative influence of traditional masculine ideologies on help receptivity and treatment engagement (Courtenay, 2010; Addis & Mahalik, 2003), we explore how John Henryism as a racially and culturally sensitive measure of both perceived control and masculine self-reliance is reflected in a treatment sample of Black men with substance use disorder.

## Hypotheses:

Using a measure of John Henryism, this study examines the variability of perceived control within an all-Black male sample in treatment for substance use disorder. In regards to inclination towards High John Henryism/Perceived Control the following hypotheses are set forth:

- 1) Within this all Black male and highly marginalized sample, we presume the sample will be skewed towards lower measures of perceive control/John Henryism overall.
- 2) Perceived control/John Henryism will be associated with distinctive within-group demographics (e.g. age, education, employment history, relationship/partner status).
- 3) Perceived control/John Henryism will be positively and separately associated with satisfaction/social adjustment measures. Those who report satisfaction in the areas of communication, leisure, role, sexuality, finances, and friends/relatives will report higher perceived control

In regards to assessing the impact of John Henryism/perceived control on treatment compliance, risk taking behavior and overall psychological wellbeing, the following hypotheses are offered:

- 1) Perceived control/John Henryism will negatively predict help receptivity, but positively predict active recovery.
- 2) Perceived control/John Henryism will positively predict decreased in drug use.
- 3) Perceived Control/John Henryism will be positively associated with reported personal wellbeing measures.

## Methods

This study uses data from a longitudinal study conducted in Detroit, Michigan over a five year period (2001-2006) (Gant, 2013). The original intent of the study was to test the efficacy of a culturally specific HIV/AIDS risk reduction intervention program for Black men receiving inpatient substance abuse treatment in urban settings (Gant, 2006). The JEMADARI Study recruited over a two year period (May 2003 through August 2005) twelve cohorts of Black men from six separate residential substance abuse treatment programs in Detroit. The present study is a secondary analysis of the first of three waves of the JEMADARI data. All analyses were conducted using SPSS version 19.0.

### Participants

Four hundred and seventy one Black men completed the initial survey. They range in age from 19 to 71 (with a mean age of 43). At the time of the study, all study respondents were current and assigned participants in residential treatment centers for drug addictions and substance use disorders at various sites in Detroit, Michigan. Seventy-four percent had had previous treatment and only thirty six percent held jobs prior to treatment. Only thirty percent had completed high school. Fifty-five percent received health insurance through public assistance and approximately twenty percent were homeless (Gant, 2013).

### Procedures:

Participant's involvement was voluntary without monetary compensation. They were asked to complete consent forms, provide personal contact information, and complete a computer based questionnaire. Participants were asked a variety of scaled and non-scaled questions about

personal demographics, substance abuse and treatment history, sexual history, perception of treatment needs, social and relational support, race and perceived overall wellbeing.

Measures:

*Perceived Control Variable:* This variable was measured by utilizing an adapted version of the 12 item John Henryism Active Coping Scale (JHAC12) (James, 1994) (see Table 1-2). Each item response was measured on a 5 point Likert scale, with scores representing the following: 1 (strongly agree), 2 (agree), 3 (undecided/unsure), 4 (disagree), and 5 (strongly disagree). Scores were gathered by summing up the 12 items responses for each respondent, with possible scores ranging from 12 to 60. The resulting scores were then collapsed into two discrete categories with 1 representing high perceived control/John Henryism participants, who succinctly and affirmatively responded to all of the JHAC 12 questions with either a 1 (strongly agree) or 2 (agree). All others were categorized as “0” and not high in perceived control/John Henryism.

While maintaining the integrity of the measure and with the permission of the scale’s designer, the originators of the JEMADARI study chose to modify three of the JHAC12 questions to make them more adaptable to the sample population (Gant, 2013). For example, one of the original scale measure questions read, “*When things don’t go the way I want them to that makes me work even harder.*” The JEMADARI study revised the sentence to read, “*When things don’t go the way I want them to that just makes me work even harder.*” A second original question from the JHAC12 measure read, “*Very seldom have I been disappointed with the results of my work.*” The JEMADARI study altered the sentence to read, “*Very seldom have I been disappointed by the results of my hard work.*” Lastly, a third JHAC12 original question read, “*I*

*feel that I am the kind of individual who stands up for what he believes in, regardless of the consequences*” was changed to read, *“I am the kind of person who stands up for what I believe in regardless of the consequences”*. Reliability analyses show a scale with good internal consistency, yielding an overall Cronbach alpha coefficient of .89.

### ***Predictor variables of Perceived Control***

#### *Sociodemographic variables:*

- 1) Age: Based on reported ages, the sample was divided into three categories: young adult (19 to 40), middle adult (40 to 64), and late adult (65 and older).
- 2) Education: Participants’ responses were classified using five categories: “elementary/some high school,” “High School Completed,” “Trade/Technical School”, “Some College”, “College/Graduate School Completed”.
- 3) Employment status: Employment status was assessed by the following two questions: “Were you employed prior to treatment?” and “Have you ever been employed?” Respondents were considered unemployed and never employed if responses were negative to both questions.
- 4) Relationship/Partner status: determined by the following survey questions “Are you currently in an intimate relationship?”
- 5) Prior Drug Use History: Determined by several selected questions: (e.g. “Have you ever consumed alcohol?”, “Have you ever used marijuana?”, “cocaine?”, or “heroin?”)

*Social Satisfaction Measures:* The following selected questions were used from the JEMADARI questionnaire to determine perceived satisfaction in varied aspects of participant's lived experience:

Communication satisfaction: *"How satisfied are you with communication and openness in your relationships?"*

Sexual Affection/Intimate Care satisfaction: *"How satisfied are you with sexual affection and care in your relationships?"*

Financial satisfaction: *"How satisfied are you with your finances?"*

Role satisfaction: *"How satisfied are you with your role in relationships?"*

Leisure/recreational satisfaction: *"How satisfied are you with recreational activities and leisure time?"*

Friend/relative relationship satisfaction: *"How satisfied are you with your relationship with friends and relatives"?*

Responses could range from 1 to 5 with scores representing the following: 1 (strongly agree), 2 (agree), 3 (undecided/unsure), 4 (disagree), and 5 (strongly disagree). For the purposes of this study and to ensure the absolute assessment of satisfaction in these areas, the scores were collapsed to render two discrete categorical variables for each question, with (1) representing those reporting "very satisfied" and "satisfied" and (0) representing all other responses.

### ***Dependent Variables of Perceived Control***

*Treatment Investment/Response Measures:* To measure treatment response and investment, the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) was used.

SOCRATES is an experimental instrument designed to assess readiness for change and treatment investment in alcohol/drug abusers (Miller & Tonigan, 1996). The instrument traditionally yields three factorially-derived scores: Recognition, Ambivalence, and Taking Steps (Miller & Tonigan, 1996). However, for the purpose of this study, only scores from two (Recognition and Taking Steps) of the three subcategories were used. Also, for the purpose of this study only, the Recognition category was renamed to Help Receptivity/Problem Recognition and the “Taking Steps” category was renamed “Active Recovery”.

1) Help receptivity/Problem recognition: The following selected questions were used to assess this variable: “I really want to make changes in my drinking/drug use.”, “If I don’t change my drinking/drugging soon, my problems are going to get worse.”, “I have a serious problem with drinking/drugs.”; “My drinking is causing a lot of harm.”, “I know that I have a drinking problem.”; and “I want help to keep from going back to the drinking/drugging problem that I had before.” Utilizing the selected questions, the current study rendered a Cronback alpha coefficient of .94.

2) Active Recovery: The following selected questions were used to assess this variable: “I have started making some changes in my drinking/drug use”; “I’ve managed to change my drinking/drug use; “I have made some changes in my drinking/drug use; “I have already changed my drinker/using; “I am actively doing things now to cut down or stop



drinking/using; : and “I am working hard to change my drinking/drug use”. Utilizing the selected questions, the current study rendered a Cronback alpha coefficient of .86

***Drug Use Decrease variable:*** To assess this variable the following selected question from the JEMADARI study was used to assess this variable: “*Have you tried to decrease your use of alcohol and/or other illicit drugs?*”

***Overall Satisfaction/Wellbeing variable:*** The following selected question from JEMADARI questionnaire was used to determine this variable: “*How satisfied are you overall?*”

## **Results**

### **Expression of Perceived Control (John Henryism)**

Participants were asked to respond to a measurement of perceived control by completing the John Henryism (JHAC-12) questionnaire. As a continuous variable, responses range from 12 to 60 with a mean of 35.21 and standard deviation of 11.39. However, for the purpose of this study emphasis was placed on the absolute presence of perceived control/John Henryism, thus the scores were collapsed into two discrete categories— with “1” representing those with high perceived control/John Henryism (cumulative scores of 12-24) and “0” representing all others. Results revealed a skewed sample, with only 92 (19.5 %) individuals reporting positive perceived control and 379 (85%) reporting the contrary. A chi-square test for goodness of fit was performed and confirmed significantly proportional differences between those reporting perceived control and those who did not  $\chi^2 (1, n=471)=.07, p<.01$ .

Additional Chi square tests for independence were completed to see if participants with perceived control and their counterparts were distributed significantly and differently across

selected demographic characteristics. As shown in Table 3-1, none of the selected demographics (e.g. age, marital/partner, education, previous employment, previous treatment involvement, or legal coercion) indicated a significant relationship with reported perceived control.

### **Perceived control predictors**

Since the dependent measure of high perceived control was discrete, direct logistic regression was performed to estimate the influence of a number of factors on participant's likelihood to report perceived control. Controlling for sociodemographics factors such as age, education, employment, current relationship, the model used six measures to assess various states of social satisfaction (e.g. communication satisfaction, financial satisfaction, sexual satisfaction, leisure satisfaction, friend satisfaction, and role satisfaction). The full model containing all predictors was statistically significant  $X^2(12, N=471) = 56.705$   $p < .001$ , indicating that the model was able to distinguish between respondents who were high in perceived control/John Henryism and those who were not. The model as a whole explained between 11.6% (Cox & Snell R-Square) and 18.5% (Naglekerke R Squared) of the variance in reported perceived control.

As shown in Table 3-2, two of the independent variables made a unique and statistically significant contribution to the model: Current relationship status and sexual satisfaction. The strongest positive predictor of perceived control was current/present relationship status, recording an odds ratio of 8.70. This indicates that, controlling for all other factors in the model, the respondents who reported being in a current intimate relationship were nearly 9 times more likely to report with high perceived control than those who did not report being in a relationship. Additionally, the odds ratio of 8.00 for sexual satisfaction indicated that for every report of

sexual satisfaction respondents were significantly 8 times more likely to report as high in perceived control. Additionally, the odds ratio approached near significance for role dissatisfaction as well, with a result of 2.70, controlling for all other factors in the model.

A simple logistic regression was performed to assess the predictive value of perceived control on help receptivity/problem recognition and active recovery. As shown in Table 3-3, results reveal that perceived control was a strong predictor of Active Recovery, recording an odds ratio of 26.660, indicating respondents with high perceived control were over 26 times more likely to report engagement in active recovery than their low perceived counterparts. In regards to Help Receptivity, perceived control was a significant negative predictor of Help Receptivity. With a statistically significant model explaining between 49% and 66% of the variance in Help Receptivity reports. With an odds ratio of .40, those with high perceived control/John Henryism were significantly less likely to be receptive to offered help.

### **Perceived Control and Risk Taking Behavior**

As shown in Table 3-3, Utilizing logistic regression and controlling for education, age, and prior employment status, the results revealed high perceived control was not a significant predictor of any decreased drug use. The odds ratio of .845 indicates a negative association, but without significance.

### **Perceived Control and Overall-wellbeing**

Utilizing logistic regression and controlling for education, age, and prior employment status, the results revealed high perceived control was a significant predictor of overall wellbeing and satisfaction (see Table 3-3). The odds ratio of 2.76 indicates those with high perceived control were more than two times likely to report overall wellbeing and satisfaction. The

coefficient of the perceived control variable had a Wald statistic equal to 180.74 which is significant at the .01 level (95% confidence level) with a critical value of 15.72 [df=7]. The overall model is significant at the .01 level according to the Model chi-square statistic.

### **Discussion**

Utilizing an all-Black male sample of individuals participating in substance abuse treatment programs, this study examined the expression of perceived control, by utilizing a measure of John Henryism. Three hypotheses were tested related to the expression and prediction of perceived control. Three other broad hypotheses were tested related to the predictive impact of perceived control on areas of treatment compliance and satisfaction. Presumably, given the sample's marginalized status, the first hypothesis was supported in that the majority of the sample reported low to no perceived control. Presumably this is indicative of the marginalized status of the population and indicates their general sense of disempowerment.

In regards to the second hypothesis, it was not supported. Perceived control/John Henryism was not significantly associated with any of the distinctive within-group demographics identified. This study showed primarily no significant differences or trends in the demographical areas of age, education, prior employment status, prior treatment history or legal coercion. While there were a few more who were positive for John Henryism/Perceived control who also reported being in a partner relationship, the difference was not significant. The insignificance of demographical variables contradicts past findings, showing age and employment to be significant variables associated with perceived control (Ross & Mirowsky, 2013). It appears that other marginalizing variables, perhaps their current state of being in treatment, trumped whatever influence the selected demographic variables may have had.

Next, it was hypothesized that selected relational satisfaction measures would positively predict perceived control/John Henryism. The results provided mixed, partly supporting our hypothesis, since not all selected relational variables were influential. The results revealed sexual/intimate care satisfaction and being in current relationship were significantly predictive of perceived control, with a near significance of role satisfaction. No other demographics or areas of satisfaction prove influential. The results may be quite meaningful from a gendered perspective. For if we view perceived control/John Henryism as a type of masculinity—a gendered style of behaving and thinking, the study implies this is best obtained when men’s sense of satisfaction in role, sexuality/intimate care, and partnership is most pronounced. Though not significant in this study, role satisfaction is particularly interesting given the considerable amount of studies identifying the importance of role in the lives of men and the resultant “role strain” experience by some when the expectations of the role are unsatisfactory or contradict the capacity to achieve (Pleck, 2007; Wade & Rochlen, 2013).

In regards to treatment response, it was hypothesized that perceived control/John Henryism, given its active coping quality, would positively predict active recovery, but not help receptivity/problem. This was supported. Perceived control was reflected not in the verbal recognition of a problem or the overt acknowledgement of need. However, high perceived control individuals were more driven to pursue their own course of intervention towards recovery. This assertion of power in a treatment setting reflects a certain pride and self-initiative that comes with perceived control and further complicates how “help” and “treatment” for Black men should be viewed. Research shows Black American men pride themselves on being strong and able to deal with adversity and view the opposite of autonomy as weakness (Thompson, Bazile, & Akbar, 2004). Through active recovery respondents with high perceived control/John

Henryism show their own independent manner in acknowledging problems and pursuing ways to make them better.

It was further hypothesized that perceived control/John Henryism would be a significant and negative predictor of decrease use. This was partly supported. The level of perceived control/John Henryism and reported frequency of use was negatively related, but not significantly. This may be exemplary of a diminished influence of will and perceived control over the influence of addiction and severe drug use behavior. Given that this is one of the first known studies to assess the relationship of John Henryism to using behavior, it would be important to see if these results are duplicated in future results.

Finally, it was hypothesize that perceived control/John Henryism will be positively associated with personal wellbeing measures. The results support this conclusion. The few who were the most satisfied in this sample were the ones with a higher perceived control/John Henryism. The study found that positive overall wellbeing seems to be a byproduct of perceived control. This corroborates studies indicating a strong sense of self-reliance and personal power may have immediate positive effects (Hammond, 2012; Matthews, Hammond, Nuru-Jeter, Cole-Lewis, & Melvin, 2013), although this may overtime be compromised when faced with persistent obstruction (Neighbors et al., 2007).

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## **CHAPTER IV**

### **MARGINALIZED CONTEXTS:**

#### **Exploring the Progressive, Contextual, and Intersectional Role of Race among Marginalize Black Men in Residential Treatment**

##### **Abstract**

First, this study examines the expression and role of race (as a contextual experience) and looks at its relationship to treatment response (help receptivity, problem recognition, and active recovery), drug use behavior, and overall satisfaction of 471 Black men in residential treatment for substance use disorder. Secondly, we examine, utilizing the Multidimensional Inventory of Black Identity (MIBI) (Sellers, Rowley, Chavous, Shelton & Smith, 1997), the expression of three racial identity variables (black centrality, black private regard, and black public regard) before and after inpatient residential treatment and the influences of these variables on participants' sense of perceived control and self-identification with a marginal "clinical" label.

In the initial study, the majority of men in the sample reported a strong black private regard, but the opposite in black centrality and black public regard. Racial identity played no significant role in reports of decrease drug use behavior or reports of overall wellbeing. Only black private regard proved nearly significant related to help receptivity/problem recognition and

active recovery. Second study results revealed the stability of black public regard, but a significant drop in black centrality and private regard post treatment and overtime. Racial identity showed minimal to no influence on participants' perceived control or tendency towards illness "addict/alcoholic" identity self-ascription. The study found racial identity was not significantly related to perceived control or illness identity ascription, regardless of residential or community setting. Neither did racial identity moderate the significant negative relationship between perceived control and self-ascription to a label.

## **Introduction**

This article is about context, which has been defined as "the set of [internal or external] conditions within which something is perceived and by which behaviors may be either curtailed or induced" (Wright & Lopez, 2009). Black men with substance use disorder who receive treatment in residential facilities face a number of influential contextual variables while in treatment that may either improve or exacerbate their marginalized status. The consideration of context is an integral and crucially important step in illuminating, if not explaining, the nuanced and varied display of group and individual behavior. Failure to consider context when examining behavior and thought may produce a skewed and constricted assessment of motives and capacities. In light of this, this article focuses on two significant contextual variables related to Black men in residential treatment: race (or racial identity) and treatment (physical) setting.

Separately race and physical settings are significant contextual variables in that both exclusively can define and steer behavior and cognition. The mere conspicuousness of race or physical setting may result in people's dramatic or reasoned change in behavior and thought. For

example, people of color have solely implicated race as reasons for their behavior and choices in health and exercise, even when competence is not a factor (Oyserman, 2010). On the other hand, several social psychological studies have shown that the manipulation of physical context alone is enough to change dramatically a person's behavior and thought (Fiske, 2010). Thus, though presumably influential separately, the interactive role of race and treatment setting is underexplored, with few studies exploring the mutable effects of race and physical setting on Black men with substance use disorder, during and post-treatment (Cole, Logan & Walker, 2011).

### **Related Theory and Research**

In early scholarly works, race has been considered principally an immutable biological designation with essential predispositions and tendencies related to specific genetic and phenotypic characteristics (i.e. skin color) (Brown, Donato, Laske, & Duncan, 2013). However, the definition of race has evolved to be considered primarily as a social construction and socially-derived pronouncement and classifier. Race demarcates a person's social standing and status, and can in turn successively lead to experiences of discrimination or inclusion. Embracing race's external and social function and meaning, this shift in the understanding of race has supported an expanded view of race that goes beyond nominal/categorical labels. Simple labels do not capture the intricacies of thought and attitude of raced individuals and fail to expose the complex and multifaceted role race plays in the lived experience of people of color. (Quintana, 2007).

Beyond being a socially imposed classifier, race is about identity and self-definition. As such, race has been characterized as an "intrapyschic contextual indicator" that informs, cues,



and guides the raced individual into ways of perceiving, behaving, and identifying (Corneille, Fife, Belgrave & Sims, 2012). Race captured as a self-identity is racial identity. Formally, racial identity has been defined as a sense of group or collective identity based on one's perception that he or she shares a common racial heritage with a particular racial group (Shriver, 2011). In sum, racial identity is an individual's statement about one's self and their perceived attachment to a racial group. This identification with a racial group membership can have important implications for the physical and psychological wellbeing and enhanced sense of belonging for marginalized individuals and members of minority racial groups (Iwamoto & Liu, 2010, Yap, Settles, & Pratt-Hyatt, 2011)

On one hand research has demonstrated several positive effects of a strong racial identity and psychological wellbeing. A strong racial identity has been associated with improved emotional and mental health (Corneille et al, 2012; Ghavami & Johnson, 2011; Sellers, Caldwell, Schmeelk-Cone & Zimmerman, 2003), and reports of less depression and distress (Yap, Settles, Pratt-Hyatt, 2011; Settles, Navaaretter, Pagano, Abdou, & Sidanius, 2010). It has been found to be a core element for many people's sense of self (Yap, Settles, Pratt-Hyatt, 2011; Brown & Brown, 2013; Kiang, Yip, Gonzales-Backen, Witkow & Fuligni, 2006), and can be closely associated with higher self-esteem and self-concepts. In their study of minority youth, Kiang et al.'s (2006) found multiple benefits emotionally and mentally correlated with strong racial identity, resulting in high self-esteem measures, fewer reports of unhappiness or anxiety despite participants' socioeconomic status or family constellation.

Additionally, strong racial identity has been found to provide guidelines for social interaction and engagement (Deaux & Martin, 2003; Oyserman & Mesmin, 2010; Gerrard, Gibbons, Brody, Murry, Cleveland & Wills, 2006). Specifically, it has been linked to decreased

involvement in risk taking behavior. People with a higher racial identity have been found to use less drugs and engage in less risky sexual behavior (Corneille et al., 2012; Smith, Phillips & Brown, 2008). Also, people with high levels of racial identity were found to be able to help resist or delay initial use of substance use (Stock, Gibbons, Walsh, & Gerrard, 2011) and expressed more negative attitudes toward substance abuse than those with lower levels of racial identity (Wallace & Fisher, 2007). Holley, Kulis, Marsiglia, and Keith (2006) found in their examination of prevention treatment programs, that intervention programs were particularly effective with people of color when they included the enhancement of racial identity as a part of the curriculum.

However, positive results are not always associated with a high racial identity. Some studies, when assessing life satisfaction or other similar outcomes, have found either no correlation between racial identity and outcome or a positive association with negative outcomes (Yip & Cross, 2004; Sellers, Copeland-Linder, Martin, & Lewis, 2006). Contradicting the findings of other studies, (Sellers, Copeland-Linder, Martin and Lewis (2006) found a strong racial identity was linked to lower life satisfaction and depression for youth and young adults. Seaton, Caldwell, Sellers and Jackson (2010) found in a sample of Black adults that those with a more central focus on race were more likely to be aware of prejudice and discrimination and thus were more likely to report discrimination and less life satisfaction. Some studies have found a negative correlation between race and treatment retention (Fuller-Rowell, Cogburn, Brodish, Peck, Melanchuk, & Eccles, 2012; Stack, Cortina, Samples, Zapato, & Arcand, 2000). Self-identified Black men were 1.58 times more likely to deteriorate post-treatment than their counterparts from other racial groups (Moos, Moos,& Finney, 2001). Specifically, McCaul, Svikis, and Moore (2001), in their study of 268 outpatient treatment clients, found that race was a significant

predictor of time in treatment, and that Black Americans were not retained in treatment as long as White Americans.

The discrepancy in how racial identity functions and the seemingly negative association racial identity has with treatment involvement and responsiveness may be partly related to the divergent approaches researchers take in the study of racial identity. Yip and Cross (2004) argue that the study of racial identity has often traveled two separate, but parallel paths, with either a focus on process or content. Process research focuses on the development of racial identity, placing heavy emphasis on the attainment of centrality and racial ascription/affiliation. The presumption is that those choosing the same racial category are at the same stage of racial identity development, and thus consider and give meaning to race in the same fashion (Yap et al., 2011). Content focus research explores the meaning and affective response race is given by the raced individual. Research shows that racial identity can serve different functions, depending on the contextual meaning a person has given to racial experience (Yap et al., 2011). Having race as a salient and central component of one's life is neither necessarily unifying with others who ascribe to the same race centrality, nor is it guaranteed to be experientially positive. A strong ascription to categorically racial variables still leaves considerable variation in how individuals perceive and respond to their raced experience (Yap et al., 2011). Therefore, assessing both the process (i.e. race centrality) as well as the content (i.e. race value and meaning) of race may explain more clearly and comprehensively the variation in how individuals perceive, respond to and are impacted by race.

The Multi-dimensional Model of Racial Identity (MMRI) (Sellers, Smith, Shelton, Rowley & Chavous, 1998) was developed in an effort to understand the complexity of racial identity and its influence on the behaviors of African Americans. The MMRI defines racial

identity in African Americans as “the significance and qualitative meaning that individuals attribute to their membership within the Black racial group within their self-concepts” (Sellers et. al, 1998). The MMRI addresses both the status of an individual’s racial identity as well as the contextual (or dimensional) experience of race at any given time. The model provides four dimensions (contexts) in which racial identity can be viewed and experienced (Shriver, 2011; Sellers et. al, 1998):

1. Salience refers to the extent to which one’s race is a relevant part of one’s self-concept at a particular moment in a particular situation.
2. Centrality refers to the extent to which a person normatively defines himself or herself with regard to race
3. Regard is the extent to which the individual feels positively about his or her race
  - a) Private regard refers to how positively or negatively an individual feels towards other African Americans and about being an African American
  - b) Public Regard is defined as the extent to which individuals feel other view African American positively or negatively
4. Ideology represents the person’s philosophy about the ways in which African Americans should live and interact with society

According to the MMRI model, the association between racial identity and outcomes depends on the vantage point and dimensional perspective one takes. Utilizing the MMRI, several studies have explored components of this model to assess the differing and moderating influences of racial identity and have shown more clearly the differential nature of these racial dimensional factors on decision making, behavior. While racial centrality is related to higher self-esteem and quality of life measures, this can be modified by a person’s level of public regard

(Kiang et al., 2006; Yap et al., 2011). Lower public regard can lead to more depression and sensitivity to discrimination (Kiang et al., 2006). Higher private regard has been found to be positively related to a sense of group belonging and nurturance and has been linked to motivation in certain individuals (Caldwell, Zimmerman, Bernat, Sellers, & Notaro, 2002; Yap et al., 2011). Given the significant difficulty there is in maintaining participation during and post treatment for Black men in substance abuse treatment, understanding how race multi-dimensionally affects Black men in treatment may be helpful.

Finally, Black men with substance use disorder in need of treatment face the prospects of engaging an additional, potentially more marginalizing contextual variable, by receiving treatment in a residential facility. Ironically, for marginalized Black men the very setting of intervention may be a source of social exclusion and further marginalization. Residential treatment has been formally described as a restrictive, but “normative, pervasive environment supporting a 24 hour per day culture and milieu of beliefs and ideology...” (Mee-Lee, Shulman, Fishman, Gastfriend, & Miller, 2013, p.1). For many, receiving services in a residential treatment setting often means the dislodgment from the community of the familiar to a physical setting of unfamiliar people, rules, and standards. In their review of cultural issues in substance abuse treatment, the SAMHSA Office of Substance Abuse Services (2004) reported findings showing African American men were less likely to complete substance abuse treatment in a residential setting and were less likely to obtain recovery than other populations. They concluded

“While others contend it is the different beliefs, attitudes and behaviors that ethnic groups hold towards health that may explain the disparity...research indicates that negative experiences with society at large have made African Americans resistant

to the idea of treatment provided by someone who represents the very society they have grown to mistrust” (p. 2)

Little is known about the interactive effects of race while residing in a marginalizing setting for treatment. What are the subsequent effects on individual’s perceived control, perception of their illness, and treatment responsiveness? With 14.2 percent of Black adults in need of alcohol treatment and 24.2 percent of those in need of illicit drug treatment receiving treatment at a specialty residential treatment facility (SAMHSA, 2010), race and setting become important variables to consider when assessing treatment capacity and success. Perhaps in understanding how Black men with Substance Use Disorders in residential treatment negotiate the contextual impact of race and setting will lead to a clearer understanding of participants’ overall treatment response and receptivity. Understanding racial identity in the context of physical setting of treatment and the community may be instrumental, in understanding reported treatment motivation and compliance.

### **Hypotheses**

Utilizing a measure of racial identity, this study explores the broad question: does race matter in treatment or explain the behavior of Black men with substance use disorder in residential treatment?

First, we assess the prevalence of Black centrality, Private regard, and Public regard within the sample population and determine its impact on treatment investment/response, reported decrease use of alcohol/illicit substances and overall satisfaction/wellbeing.

- 1) We hypothesize that the majority would promote high levels of black centrality and private black regard, but a minority of the population will report high black public regard.
- 2) We hypothesized that high black public regard, private regard and centrality will be negatively predictive of problem recognition/help receptivity, but positively predictive of Active Recovery.
- 3) We predict that high black centrality, private regard, public regard will be positively predictive of reported decrease in drug use and frequency.
- 4) We predict that high black centrality, private regard, public regard will be positively predictive of overall satisfaction.

Secondly, we examine the stability of racial identity overtime and across setting, as well as its predictive relationship to perceived control and ascription to the illness “addict/alcoholic” identity label.

- 1) We hypothesize that as a core identity, racial centrality and private regard will remain stable, with public regard decreasing upon return to the community
- 2) We hypothesize racial identity is strongly predictive of perceived control and negatively predictive of illness identity ascription and will moderate the strong relationship between the two.

## **Methods**

This study is a secondary analysis of two waves of data from a longitudinal study conducted over a five year period (2001-2006) (Gant, 2006). The original intent of the study was

to test the efficacy of a culturally specific HIV/AIDS risk reduction intervention program for Black men receiving inpatient substance abuse treatment in urban settings (Gant, 2013). The JEMADARI Study recruited over a two year period (May 2003 through August 2005) twelve cohorts of Black men from six separate residential substance abuse treatment programs in urban areas of Detroit. All analyses were conducted using SPSS version 20.

### **Participants**

Four hundred and seventy one (471) Black men between the ages of 19 and 71 completed the initial survey. All were active participants and residents in residential substance abuse treatment centers at various sites in Detroit, Michigan at the time of the study. The second wave of studies occurred within 30 day post treatment, with a drop in total number of participants to 230. The third wave of studies occurred 6 months post treatment with the final total number of participants at 181.

### **Procedures:**

Attending initially an orientation, participant's involvement was voluntary without monetary compensation. They were asked to complete consent forms, provide personal contact information, and complete a computer based questionnaire. Participants were asked a variety of standardized and unstandardized questions about personal demographics, substance abuse and treatment history, sexual history, perception of treatment needs, social and relational support, race and perceived overall wellbeing. Upon release from the treatment program, participants were given the opportunity to return to the facility or mail in responses to continue in follow up studies.



## **Measures:**

***Racial Identity Variable:*** measured by utilizing three abbreviated subscales of the Multidimensional Inventory of Black Identity (MIBI) (Sellers, Rowley, Chavous, Shelton & Smith, 1997) (see Appendix B). We used items from the centrality subscale, which assessed the importance of race to the self (e.g. Being a member of my racial group is an important reflection of who I am “). We used items from the private regard subscale, which assessed the degree to which respondents feel positively toward their racial group and to being a racial group member (e.g. I am proud to be a member of my race”). We used items from the public regard subscale, which assessed respondents’ perceptions of how the larger society views their racial group (i.e. Overall, people of my race are considered good by others”). Respondents answered 16 questions on a 5 point likert scale, with scores on the high end indicating an individual positively reported presence of the condition. Scores were obtained and subsequently collapsed into discrete categories with 1-indicating the positive presence of the variable being assessed and 0=indicating uncertainty or denial of the variable being assessed.

Socio demographic variables: For this current study, age of respondent were categorized into three age group categories: young adult ages 18-34, middle adult 35 to 54 and late adult, ages 55 and older. Respondents reported level of education achieved using five categories: “elementary/some high school,” “High School Completed,” “Trade/Technical School”, “Some College”, “College/Graduate School Completed”. Given participants’ current residence in inpatient treatment, where personal employment was not viable, participants’ employment status was assessed by the following two questions: “*Were you employed prior to treatment?*” and “*Have you ever been employed?*” Respondents were considered “previously employed” if responses were in the affirmative to one and/or both questions. Relationship/Partnership status

was determined by participants' responses to the following survey question: "*Are you currently in an intimate relationship?*"

***Treatment Investment/Response Measures:*** To measure treatment response and investment, the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) was used. SOCRATES is an experimental instrument designed to assess readiness for change and treatment investment in alcohol/drug abusers (Miller & Tonigan, 1996). The instrument traditionally yields three factorially-derived scores: Recognition, Ambivalence, and Taking Steps (Miller & Tonigan, 1996). However, for the purpose of this study, only scores from two (Recognition and Taking Steps) of the three subcategories were used. Also, for the purpose of this study only, the Recognition category was renamed to Help Receptivity/Problem Recognition and the "Taking Steps" category was renamed "Active Recovery".

1) Help receptivity/Problem recognition: The following selected questions were used to assess this variable: "I really want to make changes in my drinking/drug use.", "If I don't change my drinking/drugging soon, my problems are going to get worse.", "I have a serious problem with drinking/drugs."; "My drinking is causing a lot of harm.", "I know that I have a drinking problem."; and "I want help to keep from going back to the drinking/drugging problem that I had before." Utilizing the selected questions, the current study rendered a Cronback alpha coefficient of .94.

2) Active Recovery: The following selected questions were used to assess this variable: "I have started making some changes in my drinking/drug use"; "I've managed to change my drinking/drug use; "I have made some changes in my drinking/drug use; "I have already changed my drinker/using; "I am actively doing things now to cut down or stop

drinking/using; : and “I am working hard to change my drinking/drug use”. Utilizing the selected questions, the current study rendered a Cronback alpha coefficient of .86

**Drug Use Decrease:** Determined by selected question from the JEMADARI study: “*Have you tried to decrease your use of alcohol and other illicit drugs?*”.

**Overall Satisfaction/Wellbeing Measure:** Determined by selected question from JEMADARI study: “*How satisfied are you overall?*”

## **Results**

### **Racial Identity Descriptive**

Measurements of Black centrality, public regard and private regard were recorded from responses given to the Multidimensional Inventory of Black Identity (MIBI) questionnaire. For the purpose of this study, emphasis was placed on the absolute presence of these measures, consequently collapsing the scores into two discrete categories— with “1” representing the combined cumulative scores of “strongly agree” and “agree”, affirming the positive presence of reported centrality, private and public regard. As shown in Figure 4-1, results revealed a skewed sample on black centrality measures, with only 91 (19%) individuals reporting positively affirming black centrality and only 37 (8%) of the respondents reported a high public regard for blackness. On the measure of private black regard 390 (83%) participants reported feeling positive about being Black.

### **Predictive Value of Racial Identity on Treatment Response, Drug Use, and Overall Satisfaction**

Direct logistic regression was performed to assess the impact of black centrality, black private regard, and black public regard on two identified treatment response variables: Help receptivity/Problem Recognition and Active Recovery. In determining the predictive value of racial identity on help receptivity/problem recognition, the full model containing all predictors was determined to be statistically significant  $X^2(10, n=471)=128.70, p<.001$ , indicating the model was able to distinguish between respondents in the sample. The model as a whole explained between 26.2% (Cox & Snell R-Square) and 35.0% (Naglekerke R Squared) of the variance in reported help receptivity/problem recognition.

As shown in Table 4.1, of the three racial identity variables used in the study, only black private regard made a unique and nearly significant statistical contribution to the model. Black private racial regard recorded an odds ratio of 2.08, indicating, that if significant, respondents with strong black private regard would be over two times more likely to be receptive to help and problem recognition, than those who did not report as high in black private regard.

Logistic regression was also performed to assess the predictive value of racial identity on active recovery. As shown in Table 4.2, with a statistically significant model  $X^2(10, n=471) = 122.92, p<.001$ , results revealed that high black private regard was the only (nearly significant) racial identity predictor of active recovery. The odds ratio of .51 was less than 1, indicating that, if statistically significant, for each incident a person reported with high Black private regard, the person would be .51 less likely to report active recovery.

As shown in Tables 4-3 and 4-4, subsequent regression tests showed racial identity not to be a significant predictor of drug use behavior or overall satisfaction/wellbeing.

## **Racial Identity Relationship with Perceived Control and Illness Ascription in Treatment and Overtime Setting**

To assess the stability of racial identity among the sample population, the Friedman Test was used as a non-parametric alternative most appropriate to compensate for missing and categorical data. The Friedman test can be used when the same sample of subjects or cases is measured at three or more points in time and under different conditions. The results of the Friedman Test indicated that there was statistically significant difference in two racial identity dimensions: black centrality across time and settings,  $X^2 (2, n=471) = 27.88, p < .005$ , and black personal regard  $X^2 (2, n=471) = 288.25, p < .005$ , but no significant difference in black public regard  $X^2 (2, n=471) = 5.46, p = .10$ . Observation of the median values of both black centrality and black private regard showed a decrease in median measures from residential treatment setting to community reintegration. Using the Wilcoxon matched pairs signed rank Test--a post hoc test designed for use with repeated measures of non-continuous variables, the results revealed a statistically significant reduction in black centrality following participation in residential treatment,  $z = -4.024, p < .001$  with a small effect size ( $r = .14$ ) and in black personal regard following residential treatment,  $z = -1.881, p < .001$  with a small effect ( $r = .10$ ).

Utilizing logistic regression and controlling for education, age, and prior employment status, we assessed the impact of racial identity on John Henryism/perceived control (See Table 4-5). The results revealed racial identity had no statistical significance on the expression of perceived control/John Henryism. Only black private regard neared statistical significance in predicting the expression of John Henryism/Perceived Control. Recording an odds ratio of 2.06, if significant those reporting with positive black private regard would be slightly over 2 times more likely to report high John Henryism/Perceived Control while in treatment. Neither high

Black centrality nor Black public regard made a statistically unique contribution to reports of John Henryism/Perceived Control. The overall model is significant at the .01 level according to the Model chi-square statistic.

To assess racial identity's impact across settings and over time on John Henryism/Perceived Control, data measures from wave 3 of the JEMADARI study were assessed (See Table 4-6). The third wave of responses was conducted at a six month interval post residential stay. Using logistic regression, results delivered a statistically significant model  $X^2 (11, n=174)=35.92, p<.001$  but revealed a continued insignificant influence of racial identity on John Henryism/Perceived Control post treatment.

In assessing racial identity's impact on Illness "addict/alcoholic" Identity self-ascription, logistic regression was conducted, controlling for education, age, and prior employment status. The results revealed racial identity made no unique or statistically significant contribution to the tendency towards self-identifying with an "illness" identity label (See Table 4-7).

To assess racial identity's impact over time on the inclination toward self-identifying with an "illness identity label", data measures from wave 3 of the JEMADARI study were assessed. Using logistic regression, results delivered a statistically significant model  $X^2 (11, n=174) =52.88, p<.001$ . The study further revealed racial identity made no statistically significant contribution of illness identity post-treatment (See Table 4-8).

## **Discussion**

This study was an attempt to answer the question does race matter for Black men in the context of receiving treatment in a residential setting. Six hypotheses were formulated, utilizing a

trifurcated notion of racial identity (i.e. Black centrality, private regard, public regard) taken from the Multidimensional Inventory of Black Identity (MIBI) (Sellers et al., 1997).

### **Racial identity dimensions expression and prevalence**

Given their self-identification as Black men, it was presumed and hypothesized that the sample would be positively skewed towards black centrality and black private regard. This hypothesis was only partially supported. While the majority expressed positive private regard for their race, most of the men in this sample did not consider their race to be a central component of their lives. Though they expressed pride in their racial position, for most, race was not an integral component of their life. This finding is aligned with other studies that support the notion that favored identities are not always the guiding identity influencing behavior, but rather it is the context that makes salient the identity that induces particular behavior (Oyserman & Destin, 2010). Perhaps in the circumstance of residential treatment, black identity is secondary to other treatment related identities related to substance use disorder.

### **The Impact of race on treatment response, substance use, and overall satisfaction**

Next we examined the predictive nature of racial identity on treatment response, drug use behavior, and overall wellbeing. We hypothesized that all racial identity dimensions would be positively predictive of reported decrease in drug use and overall wellbeing. In fact, the study failed to confirm this hypothesis, by showing no significant impact of racial identity on drug use behavior or overall wellbeing. It is unclear why this occurred. This finding contradicts other studies that have found significant association with racial identity and decrease drug use (e.g. Stock et. al, 2011) and life satisfaction and wellbeing (e.g. Yap et. al, 2011).

We also hypothesize that all three racial identity measures would be negatively predictive of problem recognition/help receptivity and positively predictive of active recovery. This was disproved in that none of variables showed a significant effect on either problem recognition/help receptivity or active recovery. Only private regard approached significance in its impact on help receptivity/problem recognition and active recovery and its impact seemed to be the opposite of what was expected. Black private regard was actually nearly predictive of problem recognition/help receptivity in treatment, and negatively predictive of active recovery. In other words, had the results been significant, individuals who felt good about being Black while in the treatment setting would have more likely expressed personal vulnerability and receptiveness to assistance. Interestingly, with none of the racial identity dominions being significant, race as a central component of one's life was not fundamental to participants' treatment response and motivation.

### **Race's impact overtime and across contexts**

In assessing racial identity's impact overtime and across context, we hypothesize that as part of a core identity, racial centrality and private regard would remain stable overtime. However, this was not the case. Both Black centrality and private regard showed significant decline post treatment. Community placement did not make race more central, neither was private regard able to be maintained on average following participants re-emergence to the community. As expected, Black public regard remain relatively low and consistent.

Finally, racial identity was examined as to its effects on perceived control and "Illness" self-ascription. We learned that while in residential treatment and beyond, the only semi-meaningful racial identity predictor on perceived power and tendency towards "illness" self-



ascription was black private regard and the impact was not significant. Furthermore, positive regard continues to be somewhat influential (but never statistically significant) racial identity variable to how Black men respond in treatment and afterwards in regards to power and illness identity. For these participants, while race seems to matter, it was limited and insignificant.

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## **CHAPTER V**

### **CONCLUSION**

#### **SUMMARY OF FINDINGS**

The following will be a summary of the main findings from each of the study chapters. It ends with a discussion of the implications for social work practice.

#### **MARGINALIZED CHOICE**

With its initial focus on the expression of Choice in a drug addiction treatment setting, this dissertation highlighted the influences and implications of establishing an “illness identity” through self-ascription to the “I am an addict” identity label. Highlights of the findings follow below:

##### **1) Illness Classification is not Illness Identification**

While all in the study diagnostically qualified for drug “addiction” treatment programs, the chapter revealed a sample divided in their tendency towards self-ascription to the illness “addict/alcoholic” identity label. The results confirmed the non-deterministic nature of social ascription. Mere social assignment or clinical classification as an “addict/alcoholic” did not necessarily indicate passive acceptance and incorporation of an “alcoholic/addict” illness identity label. In fact, self-reports of drug use typically concomitant with addiction symptomology (such as high frequency and duration of substance use behavior) seemed to negatively predict, for some, self-identification with the illness “addict/alcoholic” label. This corroborates the findings

of past studies in which Black American men either did not recognize the symptoms they were experiencing as indicative of illness (Thompson, Bazile, & Akbar, 2004; VanVoorhees, et.al., 2005) or rejected and/or refused to accept the diagnosis given (Cruz, Pincus, Harman, Reynolds & Post, 2008; VanVoorhees, et. al., 2005). In sum, even with addiction treatment participation and self-reported addiction symptoms, traditional criteria for addiction were not necessarily the criteria used by the participants themselves to self-identify with the illness identity label, indicating, perhaps, a primary difference in motivation and meaning applied to “addict/alcoholic” label between the men in the study and the clinicians completing the diagnostic assessments.

## **2) Choice is regulated by the affective complexity of power, money, and sex(intimacy)**

For this sample of Black men, the findings revealed in two primary ways the complexity of choice for marginalized men in treatment and the competing sentiments that influence their social identity. First, the decision to take on additional marginal “clinical” identity labels in a treatment setting was not chiefly symptomology-based or demographically-determined, but affect driven. Self-ascription to the “illness identity” label was most contingent on relationship status and psychosocial measures of perceived satisfaction in particular facets of the lived experience. Identity proved to be most responsive to the reported affective and relational quality of one’s lived experience. This finding appears to support other research findings that show social support and overall life satisfaction measures are positively related to the increased likelihood of self-ascription to marginal labels. These results have been primarily attributed to the fact that social supports and positive affect shield against the potential negative ramifications of negative ascription to additional marginal identities (Bolden & Wicks, 2005; Conner, et al., 2010; Matthews, Corrigan, Smith, & Aranda, 2006).



Second and more pointedly, the study revealed that the acceptance of additional marginal labels in treatment settings is not **simply** contingent upon generalized positive affect (satisfaction) about life overall, but on the specific area of the lived experience in which the person reports the satisfaction. In fact, for the marginalized men in this study satisfaction played both a persuasive and dissuasive role towards illness self-identification. That is, certain life areas of satisfaction made it more likely to self-ascribe to an illness identity label, while in other life areas, satisfaction discouraged self-ascription to the additional marginal identity label. Thus, financial satisfaction was strongly and positively related to self-identification, while sexual satisfaction was a significantly dissuasive variable to “addict/alcoholic” illness identity self-ascription. For the Black men in this study sample, economic satisfaction was an effective buffer against the possible negative ramifications of incorporating a potentially pejorative identity for the men, while sexual satisfaction emboldened individuals against the acceptance of such marginal self-identification. This is an important finding for men in treatment, who like many Black men have been historically marginalized and stigmatized. Negotiating the idea of accepting an ascribed clinical/illness identity is a uniquely personal and discriminating one. Illness self-identification communicates more than an acceptance of illness and the social ascriptions linked to illness, but possibly a high (dis)satisfaction in certain areas of their lived experience. Social identification appears to not speak to the social state itself, but the individuals’ affective response and perception of his state. It is this perceived affect that influences the choice. Furthermore, the choice may be an unconventional way of expressing one’s state of being, and not simply an agreement to the severity of the illness condition itself.

### **3) Self-Ascription’s creates bifurcated path to treatment receptivity and passivity**

Finally, in relationship to “Choice” we learned the consequences of accepting the addict identity label in an addiction treatment program was mixed and varied. It was neither a certain predictor of treatment engagement (as measured in this study), nor a clear sign of treatment disengagement. While the men who self-identified with an “illness identity” label scored higher on help receptivity and problem recognition (measures showing high treatment compliance), they showed a lesser tendency to engage in active recovery (a measure of self-care initiative and independence). In this case, self-ascription seems to reveal submissiveness to structural compliance, but a diminished willingness to display self-assertion and initiative in independent pursuance of recovery maintenance strategies. Alternatively, those who did not self-ascribe with an illness identity label, although less likely to indicate problem recognition and overt help receptivity, were more likely to report pursuance and investment in active recovery treatment programs.

## **MARGINALIZED COGNITION**

The dissertation further explored the Cognition of personal power and agency, which was likened to a type of hegemonic masculinity and examined through the lenses of a cultural measure of active coping and perceived control, known as John Henryism.

### **1) Black men in treatment experience an overall sense of disempowerment while in treatment, regardless...**

With the majority of the study’s sample scoring low in perceived control/John Henryism, the dissertation reveals a sample diminished in their sense of personal agency and control over life circumstances while in treatment. More interestingly, demographic factors such as age, education, employment status prior to treatment made no significant distinguishing impact,

although all have been found to be powerful predictors of perceived control in prior studies (Ross & Mirkowsky, 2013).

## **2) Perceived personal power and affect regulate “Illness Identity” ascription**

Additionally, the results revealed self-ascription to an “illness identity” label was a direct function of one’s perceived control and personal sense of agency. Although participants were in treatment for addiction, as scores increased in perceived control/John Henryism, Black men in treatment were less likely to self-identify with an illness “addict/alcoholic” identity label. This response was regardless of duration and/or frequency of substance use. This rejection of illness identity self-labeling reflects what has been found in other studies involving Black men, in which Black men’s personal sense of mastery seems to be incompatible with their verbal report of illness symptoms (Matthews et. al, 2006; Neighbors, Musick, &Williams, 1998; Watkins et al, 2006). Both the active reporting of depressive symptomology and negative mental health effects of discrimination have been found to decreased when men report high mastery and perceived control (Watkins, Hudson, Caldwell, Siefert, & Jackson, 2011; Neighbors, Njai & Jackson, 2007)

## **3) Perceived Personal Control Leads to Personal Controlled Help Seeking**

Respondents who perceives themselves efficacious and with higher perceived control were less likely to report help receptivity, and more likely to report active recovery. This incompatibility between perceived control and help receptivity may be an important display of personal power in that their rejection of a passive form of getting help was replaced with an active style of recovery that exemplified initiative and self-reliance.

## **4) Role and Sexual Satisfaction in Partnership Leads to Perceive Power and Wellbeing**

Finally, the dissertation reflected a sample of men wherein partnership and sexual/intimate care satisfaction were most predictive of perceived control, with role satisfaction not too far behind. The combination of role and sexual/intimate care satisfaction in partnership seems to be the most empowering combination for men in treatment. A sense of mastery and control is both a beginning and an end in itself. Mastering relationship both platonically and intimately seems to lead to a greater sense of mastery overall and to an overall positive report of wellbeing

## **MARGINALIZED CONTEXT**

Assessing the contextual influence of race, the study used a trifurcated notion of racial identity taken from the Multidimensional Model of Racial Identity (MMRI), (Sellers, Smith, Shelton, Rowley & Chavous, 1998). The highlights of the Marginal Context study are as follows:

### **1) Race is not central, but personal**

The study revealed a sample high in Black private regard, but not in Black centrality. Participants regarded positively their Blackness and membership in their racial group, but did not find it central to their self-definition and in many ways did not seem to be a relevant part of their self-concept while in treatment. Additionally, public black regard was relatively low, reflecting a negative suspicion concerning the public's regard for Black people. This confirms several studies supporting the suspicion of Blacks, particularly Black men in residential settings (Garfield, 2010; Griffith, Allen, & Gunter, 2011). Given the historical context of discrimination and racism, this suspicion is understood and expected. However globally pessimistic and

racially decentralized the participants were, they still reported relatively high in their private regard of race while in treatment.

## **2) Racial Context matters some, but Physical Context matters more**

The study revealed the minimal impact of racial identity on participants' treatment response, drug use behavior, and reports of wellbeing. Even private personal regard which came the closest to influencing treatment response, particularly in the area of help receptivity, never did so significantly. Neither did race influence people's perceived control or tendency towards self-ascription to the illness identity label. Yet, physical setting affected how race was experienced and expressed. Individuals returning to the community post residential treatment showed a significant drop in the black private regard and black centrality. Perhaps this was the result of experiences participants faced upon their return to the community, where the salience of addiction and drug treatment issues was replaced with the more glaring examples of racism and discrimination.

## **3) Race is Dynamic, contextual, but not a mediator**

Finally, racial identity was found to be dynamic and capable of changing across contexts. The expression of black centrality and private racial regard were most poignant during participants' stay in residential treatment. Upon their return back to the community, the dynamics and presentation of race change.

Before exploring more thoroughly the practical implications of this dissertation's findings, we must first appreciate the intersectional nature of Marginal Choice, Marginal Cognition, and Marginal Context. Though the concepts were examined separately and quantitatively, all contributed simultaneously, holistically and qualitatively to the lived

experience of the men involved. In the introduction several questions were asked about the multiply marginalized men in this study. Some of those questions are revisited in their revised form with answers revealing the importance of understanding the complexity of the men involved and the intersectional nature of their responses.

- *In the context of Illness, do marginal men in treatment choose to ascribe to themselves additional marginal labels?* The answer is the **Choice** to ascribe depends on “satisfaction states” and the **Cognition** of perceived control, while experienced in the **Context** of a residential treatment.
- *Is choosing to ascribe to additional marginal clinical labels more or less detrimental?* The response is yes, more or less. **Choosing** to self-ascribe is seemingly less detrimental for men while in the **Context** of residential treatment in that they are more willing to receive help and recognize their problems, but in doing so these men reflect a **Cognition** that is associated with a diminished sense of power and personal control.
- *In the context of gender, does perceived power remain prevalent in a treatment setting?* The answer is on the most part no, but not for all. **Cognition** of perceived control is especially strong when one **Chooses** not to self-ascribe to an Illness identity label while in the **Context** of treatment.

And finally

- *For Black men, does the Context of race matter?* The answer is the **Context** of race is somewhat important, but not significantly, especially when one **Chooses** to self-ascribe to an illness identity or has a high **Cognition** of personal control.

## IMPLICATIONS

Viewing men in general and Black men in particular from a different set of lenses is perhaps the first step to a better understanding of these men and towards the development of more effective intervention and treatment strategies for them (Furman, 2010). This “new set of lenses” seems to first include rejecting the presumptuous notion of Black men’s homogeneity and the decisions to understand them solely as a social whole, without considering the idiosyncratic nature of their decisions. The results of this dissertation provided a vivid example that even when similar in many, if not most, respects; Black men in treatment can and are significantly divided in their clinical choices and decisions, particularly about their clinical identity and response to traditional clinical categories and diagnostic systems.

Dominelli (1996) indicates effective social work and treatment of t Black men in treatment is unlikely to be realized if it relies on risk assessments and classic therapeutic approaches that reject a willingness to discard rigid notions of classifications and expectations. Traditional evaluative tools, such as the renowned and popularly used Diagnostic Statistical Manual of Mental Disorders, may not effectively explain the connections between environment, culture, behavior, thoughts, emotions, external supports and functioning. Often assessment tools using a classification system are limited in that they may suggest somewhat vaguely what needs to be changed, but fail to provide guidelines on how to facilitate the noted change (Maddux, 2008). Traditionally, conceptualizations of behavior have focused on symptomatology and dysfunction. However, results from this dissertation showed perceived affect and satisfaction levels are significantly important in contributing to how marginal men respond to their identification with illness and their sense of personal control and capacity. Clinicians should take the time to ascertain client satisfaction levels in multiple areas of the lived experience;

namely in regards to intimate relationships, finances, and perceived control. Assessing satisfaction levels may not only result in men's more positive response to treatment, but may also impart to the clinician a richer insight into the true meaning of men's self-attributions while in treatment.

The focus on the negative aspects has often occurred at the expense of identifying strengths (Lopez, Edwards, Pedrotti, Prosser, LaRue, Spalitto, & Ulven, 2006). What is needed is an appreciation of alternative conceptualization standards that consider the individualized and intersectional impact of gender, race and ascribed pathology (when relevant). Some have suggested, regardless of men's negative presentation in society, that marginalized men should be viewed not from a deficit perspective, but from a strength or agentic based perspective (Furman, 2010; Addis & Mahalik, 2003). This perspective, such as the one introduced and supported through the area of positive psychology, encourages a shift in emphasis from a focus on weakness, disease and deficit to that of strength, virtue, and promise of human development (Seligman, 2008). For example, as revealed from the results of this dissertation, satisfaction in relationship and role responsibility matters to marginalized men, and an affirmation and acknowledgement of such in treatment could be instrumental in encouraging more investment and diligence on the part of male participants. It is through this expanded and improved view and understanding of Black men who suffer with various pathologies and seek treatment, that more can conceivably be understood about the men who fail to participate or engage in treatment.

Kiselica and Englar-Carlson (2010) proposes the Positive Psychology/Positive Masculinity (PPPM) model which emphasizes male strengths as the starting point for psychotherapy. It is also important to help men identify positive aspects of the various masculinities that have contributed to their adaptation and their own wellbeing (Addis &



Mahalik, 2003). Once trust and positive sense of masculinity has been established, clinician can begin to move forward by helping men understand (when applicable) how masculinity scripts have impeded them from living authentic and genuine lives. This can be done by helping them see the unrealistic standards imposed upon them and their own role in maintaining them at a cost to their development and others (Mahalik, Locke, Theodore, Cournoyer & Lloyd, 2001).

Furthermore, clinical work with Black men must include an assessment of power in the context of gender/raced related work in individual clinical work. This seems to require a thorough assessment of men's perceived sense of personal control, which may, for many be indicator of their own sense of manhood (Riska, 1996; Kimmel, 2000). As is noted in the findings of this dissertation, not only was participants' reports of perceived control directly related to their reports of active recovery, but also appears to mitigate their reports of illness and induced greater satisfaction. Interestingly, for Black men in treatment it appeared that perceived control trump the role of racial identity attitudes in mediating and negotiating illness in the residential setting. Thus, finding ways to accentuate marginalized men's perceived sense of personal power while in treatment may be instrumental in ensuring continued and active progress in the community. This is an area in need of further exploration, but it appears that one of the first avenues to use perceived control as positive function is address the significant link between relationships, sexual/intimate care, and perceived control. When men reported being in a current relationship and overall satisfaction with sexuality and intimacy, the odds of reported perceived control increased. Relationship enhancement and establishment may be an absolute key to reinvigorating men who are marginalized and overwhelmed by social circumstances. Therapists must begin to recognize and examine the value of this expanded gender/race aware perspective when working with Black men in treatment affirming power without fearing its backlash

(Kilmartin, 2010). This notion of empowerment and affirming has been a longstanding and integral component of effective social work practice and intervention, especially for those in marginalized positions (Gutierrez, 1998)

Clinical social workers, in general, can help men in treatment become more aware of how the negative ramifications of adherence to a strict "masculine ideology" and the difference between power that benefits instead of harms when it is not sufficiently disciplined or interpreted as power over and oppose to with. Gilbert & Scheer (1999) promotes a Gender Aware Therapy approach, which incorporates five broad principles: 1) to regard conceptions of gender as integral aspects of counseling and mental health, 2) to consider problems within their societal context, 3) to actively seek to change gender injustices experienced by men, 4) to emphasize development of collaborative therapeutic relationships, 5) to respect clients' freedom to choose despite what is "politically correct," "traditional," or "nontraditional"

Additionally, since to do social work with substance use disorders means to largely work with Black men, the concept of perceived control and race and the impact of racism in the lives of these men must also be taken into deliberate consideration. However, the findings from this dissertation showed that marginal Black men did not reflect a diminished racial regard. Most reflected a positive personal regard for their race, but instead reported a generally low public regard, indicating a belief that others outside their racial classification felt less positively about their racial status. Intervention should involve approaching Black men emphatically and with an understanding of the pain or dissatisfaction they may be experiencing while in treatment (Griffith et al., 2011; Wade, 2009).

Roberts (2007) suggests that social workers must return to the idea of rehabilitation and cultural sensitivity when working with Black men, in particularly racial minority men. Franklin

& Boyd- Franklin (2000) described the above types of interaction between Black men as sanity checks. These sanity checks seem to serve the function of keeping Black men connected to the community, while providing a system for validation and promoting well-being. African men reported positive outcomes when they were able to speak about both racial and other experiences in a group setting with other African American men (Addis & Mahalik, 2003; Wade, 2009). Thus, there is a social component that is apparent for Black for dealing with stress.

Finally, clinical social worker could provide the opportunity for identification, communication, and bonding with other men of like experience to address the experiences of alienation and suffering that can come from being both Black and male. This may be particularly successful for some African American males. Franklin (1992) observed that working class Black men were more accessible to each other in their friendships than were their middle-class counterparts. Emotional intimacy, according to Franklin, could be preserved, because working class Black men experience greater isolation from mainstream society than upwardly mobile Black men, “(and) thus may not internalize the same taboos against male same sex friendships, which result in non-self-disclosure, competitiveness, and non-vulnerability” (Franklin, 1992, p. 201).

### **STUDIES LIMITATIONS and FUTURE DIRECTIONS**

There are several limitations to this study. First, the research study use of only Black men with substance use disorder in residential treatment limits perhaps a broader applicability. It affects the ability to generalize the results to other populations, such as men receiving services in outpatient treatment programs, women, youth, and drug treatment neophytes. Future studies

should ascertain if similar results follow for members of other groups who are affected by substance abuse and addiction and mental health disorders.

For this study all data were secured solely by self-report with no component to confirm, when possible, the validity of the participant's responses. This is particularly important in respect to the types of questions asked to those who, in this sample, were legally coerced and involved in the criminal justice system. There is a possibility that participants attempted to present themselves in a positive light. Although anonymous in their participation, particularly, the legally coerced are undoubtedly aware that any unflattering revelations or verified reports of illicit drug use could carry with it a heavy legal price.

Another limitation of this study is the lack of opportunity for participants to elaborate more thoroughly on the answers given. This study would have been greatly benefited having a qualitative component to it, allowing for follow up and elaboration of the answers given. We could, for example, further explore narratively, and thus more deeply why certain satisfactory states dissuade or persuades personal control beliefs or examine why racial identity seem not to matter at times for Black men in treatment. Also, the limited number of questions chosen to assess such broad conceptual categories is certainly problematic and may have reduced the scope of knowledge obtained and weakened the integrity of the findings garnered. This certainly could be countered with qualitative assessment.

Another important issue that emerged from this study was the realization that ascribed diagnostic terms, such as "addict (ion)" can simultaneously hold different meanings for Black men. We have made an assumption that self-ascribing to an "addict" label is an indication of ascription to "illness" identity, but this may not be so. For some, addiction may be more of a behavioral descriptor and not in any way a marker of identity. Future studies should more

qualitatively explore the language and characterization of addiction and illness among respondents and how they and others define the term addiction or other potentially pejorative clinical terms used to describe clinical symptoms. Research would also focus more explicitly on the origins of these meanings. In other words, data-gathering instruments should thoroughly probe how respondents come to understand their meaning of their diagnosis and other health- and treatment-related terms as well. Doing so, may lead to a better understanding of how “illness” and “help receptivity” is conceptualized, shaped, and translated among Black men and other marginalized persons.

## **CONCLUSION**

Accounting for Black men’s personal perceptions and identities within the therapeutic setting, this dissertation quantitatively assessed the cognitions, choices and contexts of Black men engaged in residential treatment and beyond. The primary objective of this dissertation was to explore descriptive intragroup differences amongst a sample of Black men similarly and multiply marginalized by race, gender, ascribed illness and clinical placement. More specifically, this dissertation’s goal was to better understand the overall clinical experience of Black men in treatment, through ascertaining their tendencies towards clinical self-ascription, perceived power, and reported racial regard. The effects of these were then examined in conjunction with participants’ overall clinical adjustment, as measured by treatment receptiveness (problem recognition, help receptivity, and active recovery), reported risk taking behavior and overall wellbeing. In sum, all of the studies revealed the heterogeneity of perceptions within a (nearly) homogeneous sample of urban Black men, showing that common dispositional factors alone do not fully explain the varied display and expressions of identities through gender, race and illness.

This research contributes to the increasing body of work in minority mental health, with a focus on understanding Black men (and men in general) within the context of help-seeking and mental health service consumption. This is important given the documented racial and gender disparity evident in the utilization and underutilization of mental health treatment services in the U.S. Additionally, since the number of studies dedicated to Black American men's mental health, gender, and illness identity remains comparatively small in both the psychological and social work disciplines, the findings of this dissertation can hopefully contribute to, if not advance, the scholarship in these areas. Also, by incorporating an intersectionality and social constructionist perspective, it pushes the field forward in better understanding the interstitial nature of race, gender, and psychological disorder/illness and how a sample of marginal Black Americans men involved in treatment identify with their Blackness, Maleness, and illness during and after their treatment intervention. It is hoped that the findings of this dissertation expand the clinical profile of the Black male consumer in ways that will better inform and enhance the interventions designed to improve their lives and wellbeing.

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## **TABLES**

**Table 1-1-Descriptive Characteristics of Overall sample (N = 471)**

Variables	Frequency	%	Mean Age First Used
<b>Age</b>			
Young Adult (18-34 yrs)	40	8.5	
Middle Adult (35-54 yrs)	383	81.3	
Late Adult (55 yrs +)	48	10.2	
<b>Education Level:</b>			
Elementary/Some High School	171	36.3	
High School Graduate	141	29.9	
Trade/Technical School	48	10.2	
Some College	83	17.6	
College Graduate	22	4.7	
<b>Economic</b>			
Employed (before treatment)	165	36.4	
Public Assistance	282	59.1	
<b>Relationship/Family Status</b>			
Current Partnering Relationship <sup>a</sup>	208	44.2	
Have Children <sup>b</sup>	359	76.2	
<b>Drug Use Experience/Ever Consumed/Used</b>			
Alcohol	388	82.4	N/A
Marijuana	389	82.6	15
Cocaine	423	89.8	23
Heroin	164	34.8	19
<b>Treatment History</b>			
Previous Trmt	348	73.9	
Previous Trmt Comp.	240 <sup>b</sup>	71.4 <sup>b</sup>	
Prior Trmt Comp. w/in past 2years	189 <sup>b</sup>	51.6 <sup>b</sup>	
1-4 previous trmt placements prior	251 <sup>b</sup>	70.1 <sup>b</sup>	
<b>Current Treatment Status<sup>a</sup></b>			
Legally-Mandated	125	26.5	

**Table 2-1. Chi-square and *P*-values of observed values for Self-Ascribed Illness identity**

<i>Variable</i>	<i>Chi-square</i>	<i>d.f.</i>	<i>P-value</i>
Legally Coerced <sup>b</sup>	1.171	1	0.19
Education <sup>c</sup>	3.617	4	0.46
Prior Employment <sup>d</sup>	.153	1	0.63
Previous Treatment <sup>b</sup>	6.702	4	0.15
Age <sup>b</sup>	.057	2	0.97
Parent <sup>b</sup>	.179	1	0.67
Current Relationship <sup>b</sup>	.994	1	0.31
Ever Used Marijuana <sup>b</sup>	2.397	1	0.12
Ever Used Cocaine <sup>b</sup>	.002	1	0.96
Ever Used Psychedelics <sup>b</sup>	.595	1	0.44
Ever Used LSD <sup>b</sup>	.013	1	0.91
Ever Used Heroin <sup>b</sup>	.392	1	0.53

a. Significant at  $P \leq 0.05$ .

b. N=471

c. N=465

d. N=453

**Table 2-2: Logistic Regression Model Estimating Affect States/Perceived Control on Illness Self-Ascription (n = 471)**

Variable	<i>B</i>	<i>SE</i>	<i>p Value</i>	<i>OR</i>	<i>95% C.I.</i>
Communication Satisfaction	0.41	0.81	.615	1.51	0.31 – 7.43
Financial Satisfaction	2.82	0.78	.000*	16.79	3.63-77.73
Sex/Intimate Care Satisfaction	-3.04	0.84	.000*	.04	.01-.25
Friend/Relative Satisfaction	0.55	0.55	.411	.41	0.46-6.53
Role Satisfaction	-.76	0.83	.361	.46	.09-2.40
Perceived Control	-.23	95.54	.000*	.79	.76-.83
Current Partner	2.28	0.65	.000	9.78	2.71-35.20
(Constant)	11.33	1.65	.000		

*Model  $\chi^2 = 309.172, df = 15, *p < .001$*

<sup>a</sup>Controlling for demographics e.g. age, education, prior employment, legal coercion, current relationship

**Table 2-3. Self-Ascription Effects on Treatment Response, Risk-Taking Behaviors, and Overall Satisfaction**

	Help Receptivity			Active Recovery			Risk-Taking Behaviors: HIV Testing <sup>2</sup>			Overall Satisfaction		
	$\beta$	SE	OR	$\beta$	SE	OR	$\beta$	SE	OR	$\beta$	SE	OR
Illness Label Self Ascription	5.337**	.469	207.89	-5.371**	.501	.005	-1.052	.212	.527	-1.75**	.395	.243
X <sup>2</sup> (Model) <sup>1</sup>		433.83			418.59			6.194			176.219	
Df Constant	-4.190	7		3.532	7		-.232	7		-1.705	7	

Note.

1) All models control for age, prior employment status, marital/partner status, education, perceived control and legal coercion status (omitted from the table).

2) The Risk Taking Behavior also assessed # of Sexual Partners and Condom Use. Since neither prove significant they are omitted from the table.

\* p < .05. \*\* p < .01. \*\*\* p < .001.

**Table 3-1. Chi-square and *P*-values of observed values in relation to Perceived Control/High John Henryism**

<i>Variable</i>	<i>Chi-square</i>	<i>d.f.</i>	<i>P-value</i>
Legally Coerced <sup>b</sup>	.024	1	0.88
Education <sup>c</sup>	.805	4	0.94
Prior Employment <sup>d</sup>	.262	1	0.61
Previous Treatment <sup>b</sup>	.813	4	0.37
Age <sup>b</sup>	3.591	2	0.17
Parent <sup>b</sup>	.978	1	0.32
Current Relationship <sup>b</sup>	.070	1	0.80
Ever Used Marijuana <sup>b</sup>	2.824	1	0.90
Ever Used Cocaine <sup>b</sup>	.087	1	0.67
Ever Used Psychedelics <sup>b</sup>	.071	1	0.79
Ever Used LSD <sup>b</sup>	3.398	1	0.07
Ever Used Heroin <sup>b</sup>	3.398	1	0.065

a. Significant at  $P \leq 0.05$ .

b. N=471

c. N=465

d. N=453

**Table 3-2: Logistic Regression Model Estimating Effects of Affective States on Perceived Control/John Henryism (n = 471)**

<b>Variable</b>	<b><i>B</i></b>	<b><i>SE</i></b>	<b><i>p Value</i></b>	<b><i>OR</i></b>	<b><i>95% C.I.</i></b>
Communication Satisfaction	0.92	0.46	.864	1.10	0.38 – 3.13
Financial Satisfaction	-0.50	0.52	.342	0.61	.220-1.69
Sex/Intimate Care Satisfaction	2.08	0.53	.000*	8.00	2.82-22.72
Friend/Relative Satisfaction	0.13	0.47	.777	1.14	0.46-2.86
Role Satisfaction	1.99	0.53	.008	2.70	.95-7.62
Present Relationship	2.16	0.58	.000*	8.70	2.77-27.20
(Constant)	11.33	1.65	.000		

*Model*  $\chi^2 = 55.62$ , *df* = 15, \**p* < .001

<sup>a</sup>Controlling for demographics e.g. age, education, prior employment, legal coercion, current relationship



Table 3-3. Perceived Control/John Henryism Effects on Treatment Response, Drug Use Behavior, and Overall Satisfaction

	Help Receptivity			Active Recovery			Decrease Drug Use Behavior			Overall Satisfaction		
	$\beta$	SE	OR	$\beta$	SE	OR	$\beta$	SE	OR	$\beta$	SE	OR
High Perceived Control/ John Henryism	-3.229***	1.138	.040	3.283**	1.153	26.660	-.168	.265	.845	1.016*	.445	2.763
X <sup>2</sup> (Model)		433.83			418.59			6.194			176.219	
Df		7			7			7			7	
Constant	-4.190			3.532			-.232			-1.705		

Note. A All models control for age, prior employment status, marital/partner status, education, illness self-ascription and legal coercion status (omitted from the table). ‘

\* p < .05. \*\* p < .01. \*\*\* p < .001.

Table 4-1: Logistic Regression Model Estimating Effects of Racial Identity on Help Receptivity/Problem Recognition (n = 471)

<b>Variable</b>	<b>B</b>	<b>SE</b>	<b>p Value</b>	<b>OR</b>	<b>95% C.I.</b>
High Black Centrality	-0.49	0.28	.080	0.61	0.35 – 1.06
High Black Private Regard	0.73	0.30	.014	2.08	1.16-3.71
High Black Public Regard	-0.78	0.42	.854	0.93	0.41-2.11
(Constant)	-1.29	0.67	.053		

Model  $\chi^2 = 128.701$ ,  $df = 10$ ,  $*p < .001$

<sup>a</sup>Controlling for demographics e.g. age, education, prior employment, legal coercion, current relationship

Table 4-2: Logistic Regression Model Estimating Effects of Racial Identity on Active Recovery (n = 471)

<b>Variable</b>	<b>B</b>	<b>SE</b>	<b>p Value</b>	<b>OR</b>	<b>95% C.I.</b>
High Black Centrality	0.25	0.28	.379	1.28	0.74-2.21
High Black Private Regard	-0.67	0.29	.023	0.51	0.29-0.91
High Black Public Regard	-0.35	0.43	.407	0.70	0.30-1.62
(Constant)	1.00	0.65	.128		

Model  $\chi^2 = 122.924$ ,  $df = 10$ ,  $*p < .001$

<sup>a</sup>Controlling for demographics e.g. age, education, prior employment, legal coercion, current relationship

Table 4-3: Logistic Regression Model Estimating Effects of Racial Identity on Decreased Drug Use (n = 471)

<b>Variable</b>	<b>B</b>	<b>SE</b>	<b>p Value</b>	<b>OR</b>	<b>95% C.I.</b>
High Black Centrality	0.40	0.25	.113	1.49	0.91-2.44
High Black Private Regard	0.42	0.27	.115	1.52	0.90-2.55
High Black Public Regard	0.08	0.36	.836	1.08	0.53-2.20
(Constant)	-0.43	0.57	.453		

*Model  $\chi^2 = 8.286, df = 10, *p < .001$*

<sup>a</sup>Controlling for demographics e.g. age, education, prior employment, legal coercion, current relationship

Table 4-4: Logistic Regression Model Estimating Effects of Racial Identity on Overall Satisfaction (n = 471)

<b>Variable</b>	<b>B</b>	<b>SE</b>	<b>p Value</b>	<b>OR</b>	<b>95% C.I.</b>
High Black Centrality	-0.29	0.42	.498	0.75	0.33-1.72
High Black Private Regard	0.62	0.58	.284	0.72	0.27-1.91
High Black Public Regard	0.58	0.45	.298	1.85	0.60-5.74
(Constant)	-22.21	2378.67	.993		

*Model  $\chi^2 = 154.686, df = 10, *p < .001$*

<sup>a</sup>Controlling for demographics e.g. age, education, prior employment, legal coercion, current relationship

Table 4-5: Logistic Regression Model Estimating Effects of Racial Identity on Perceived Control/John Henryism(while in Residential treatment-Wave 1) (n = 410)

<b>Variable</b>	<b>B</b>	<b>SE</b>	<b>p Value</b>	<b>OR</b>	<b>95% C.I.</b>
High Black Centrality	1.40	0.25	.113	1.49	0.91-2.44
High Black Private Regard	1.42	0.27	.020	2.06	0.90-2.55
High Black Public Regard	1.08	0.36	.836	1.08	0.53-2.20
(Constant)	-0.43	0.57	.453		

Model  $\chi^2 = 35.92$ ,  $df = 10$ ,  $*p < .001$

<sup>a</sup>Controlling for demographics e.g. age, education, prior employment, legal coercion, current relationship

Table 4-6: Logistic Regression Model Estimating Effects of Racial Identity on Perceived Control/John Henryism (in the Community-Wave 3) (n = 174)

<b>Variable</b>	<b>B</b>	<b>SE</b>	<b>p Value</b>	<b>OR</b>	<b>95% C.I.</b>
High Black Centrality	-0.29	0.42	.498	0.75	0.33-1.72
High Black Private Regard	1.62	0.58	.070	3.60	0.27-4.91
High Black Public Regard	0.62	0.58	.284	1.85	0.60-5.74
(Constant)	-22.21	2378.67	.993		

Model  $\chi^2 = 35.92$ ,  $df = 10$ ,  $*p < .001$

<sup>a</sup>Controlling for demographics e.g. age, education, prior employment, legal coercion, current relationship

Table 4-7: Logistic Regression Model Estimating Effects of Racial Identity on Illness Identity (in Residential-Wave 1) (n = 410)

<b>Variable</b>	<b>B</b>	<b>SE</b>	<b>p Value</b>	<b>OR</b>	<b>95% C.I.</b>
High Black Centrality	1.40	0.25	.113	1.49	0.91-2.44
High Black Private Regard	-0.42	0.27	.025	.51	0.40-2.55
High Black Public Regard	1.08	0.36	.836	1.08	0.53-2.20
(Constant)	-0.43	0.57	.453		

*Model  $\chi^2 = 27.88$ ,  $df = 10$ , \* $p < .001$*

<sup>a</sup>Controlling for demographics e.g. age, education, prior employment, legal coercion, current relationship

Table 4-8: Logistic Regression Model Estimating Effects of Racial Identity on Illness Identity (in the community-Wave 3) (n = 174)

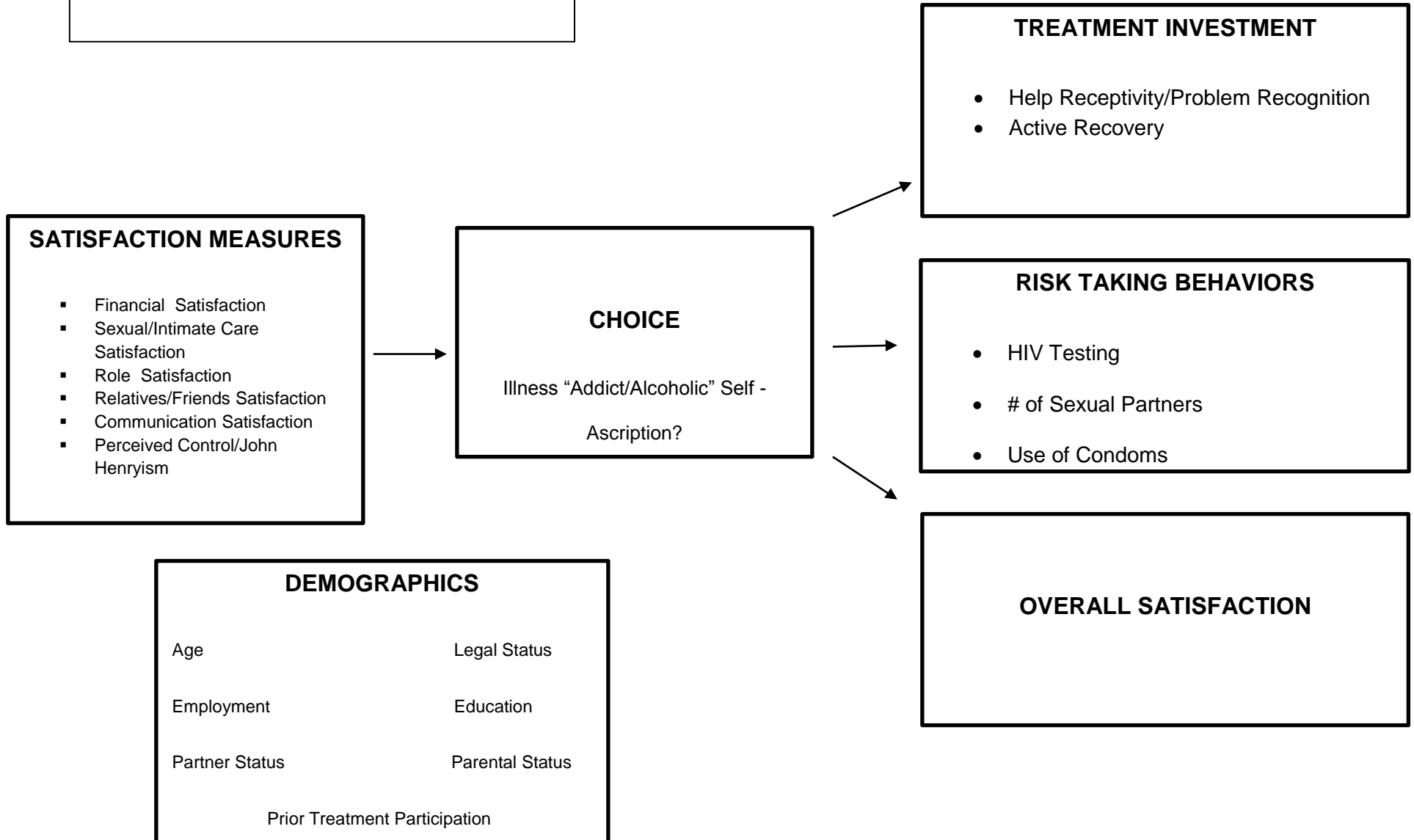
<b>Variable</b>	<b>B</b>	<b>SE</b>	<b>p Value</b>	<b>OR</b>	<b>95% C.I.</b>
High Black Centrality	-0.29	0.42	.498	0.75	0.33-1.72
High Black Private Regard	1.62	0.58	.070	3.60	0.27-4.91
High Black Public Regard	0.62	0.58	.284	1.85	0.60-5.74
(Constant)	-22.21	2378.67	.993		

*Model  $\chi^2 = 52.88$ ,  $df = 10$ , \* $p < .001$*

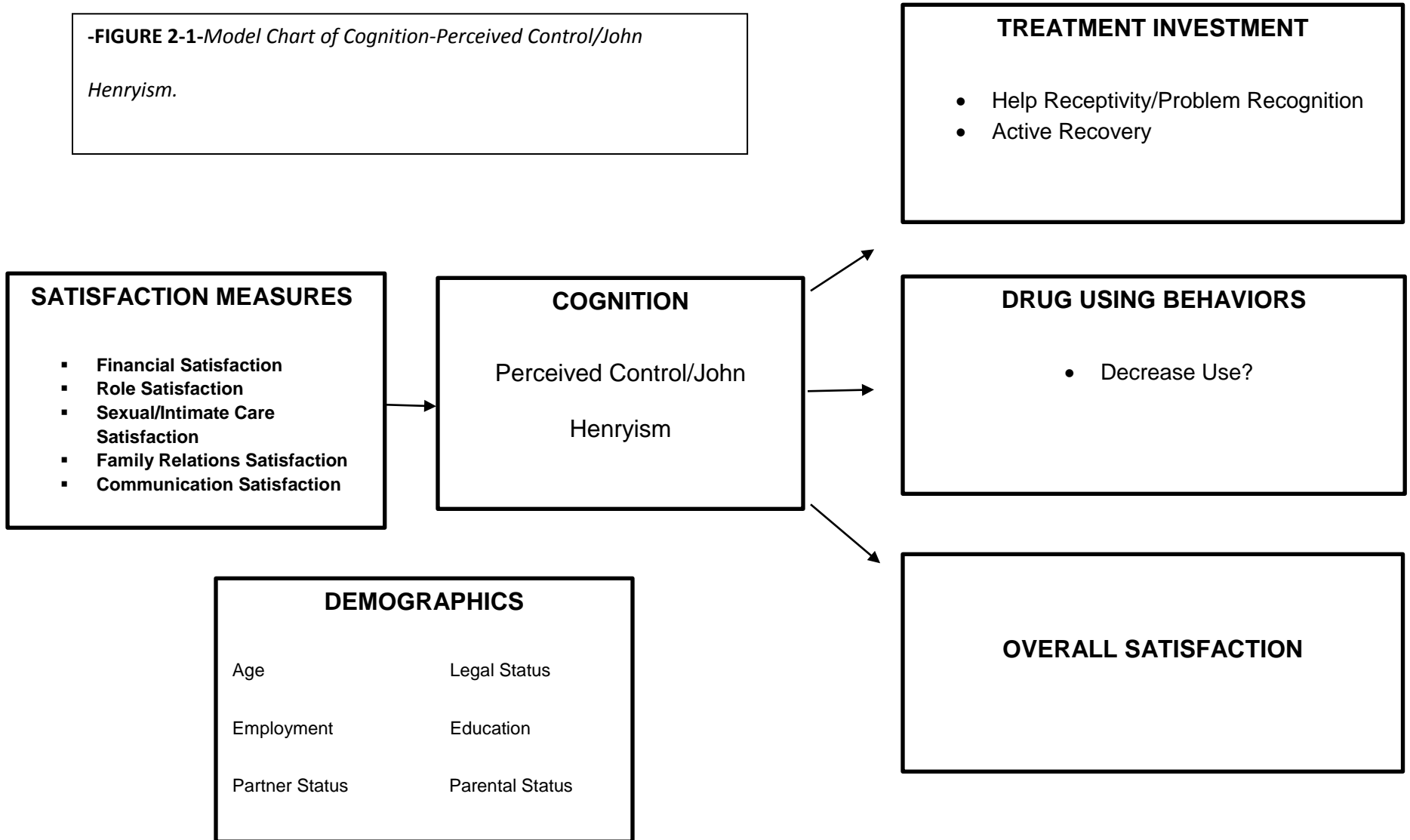
<sup>a</sup>Controlling for demographics e.g. age, education, prior employment, legal coercion, current relationship

## **FIGURES**

**FIGURE 1- 1- Model Chart of Choice-Self-Ascription**

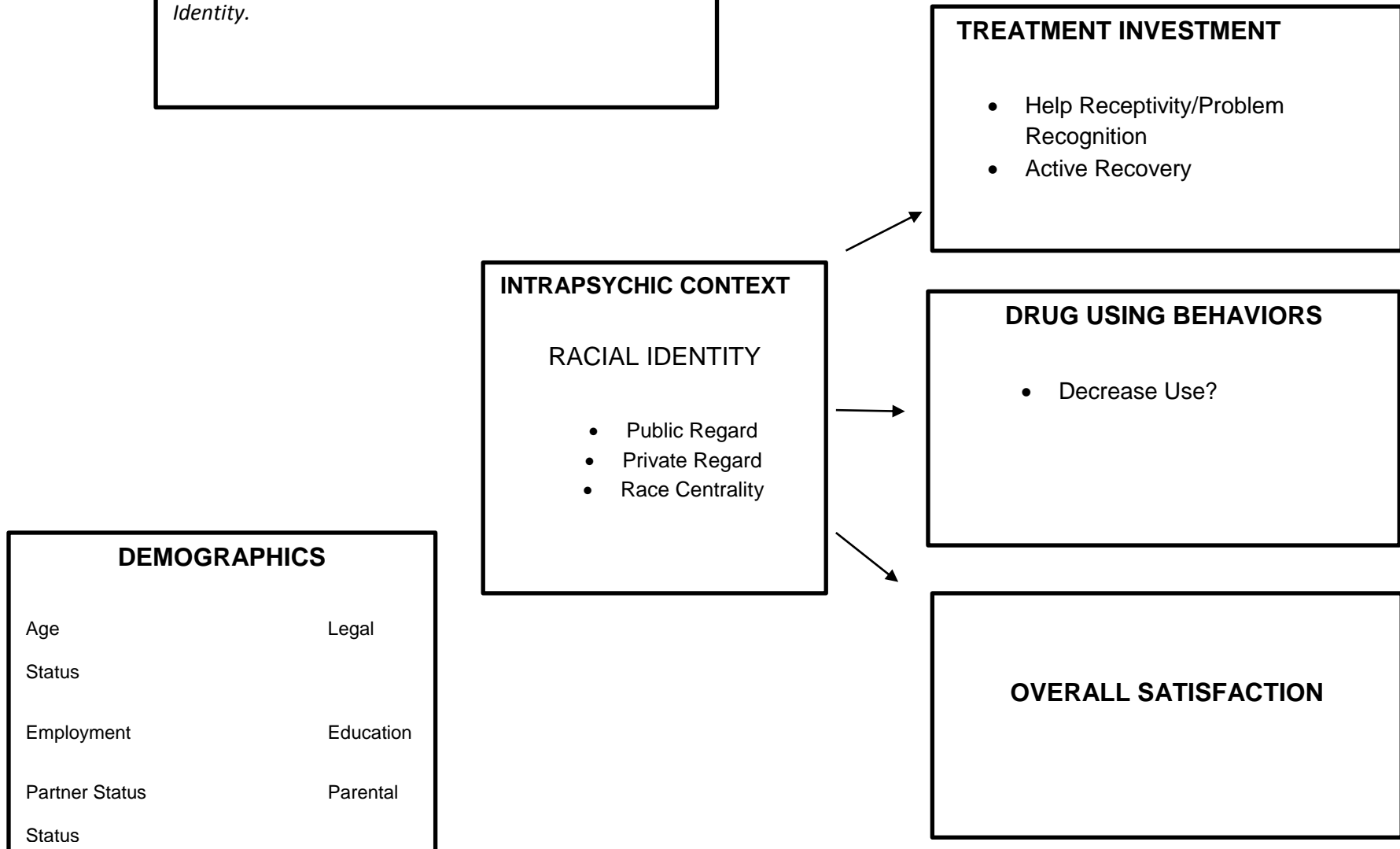


**-FIGURE 2-1-Model Chart of Cognition-Perceived Control/John Henryism.**

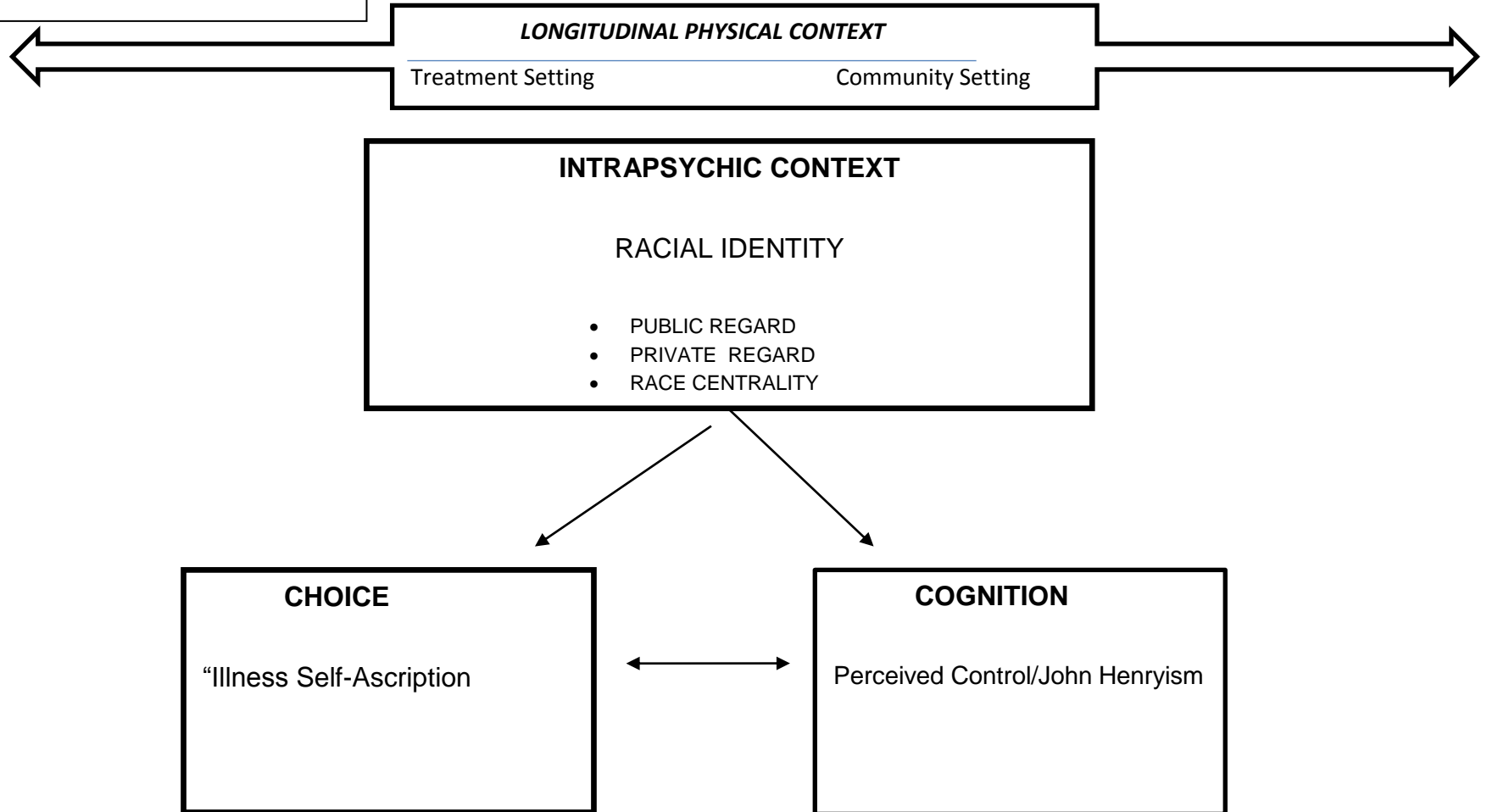




**FIGURE 3- 1-Model Chart of Intrapsychic Contextt-Racial Identity.**



**-FIGURE4-1** –Model Chart of Physical Context-  
Residential vs. Community .



## **APPENDICES**

APPENDIX A  
JEMADARI SURVEY  
MEASURES FOR PERCEIVED CONTROL

(Adapted from John Henryism Active Coping Scale-JHAC-12, James,1994)

A5AW1. I've always felt I could make of my life pretty much what I wanted to make of it

A5BW1. Once I make up my mind to do something, I stay with the job until it's completely done

A5CW1. I like doing things that other people thought could not be done

A5DW1. When things don't go the way I want them to that just makes me work even harder

A5EW1. Sometimes I feel that if anything is going to be done right, I have to do it myself

A5FW1. It's not always easy, but I manage to find a way to do the things that I really need to get done

A5GW1. Very seldom have I been disappointed by the results of my hard work

A5HW1. I am the kind of person who stands up for what I believe in regardless of the consequences

A5IW1. In the past, even when things got really tough, I never lost sight of my goals

A5JW1. It's important for me to do things the way I want to do them

A5KW1. I don't let my personal feelings get in the way of doing a job

A5LW1. Hard work has really helped me to get ahead in life

## APPENDIX B

### JEMADARI SURVEY

#### MEASURES FOR RACIAL IDENTITY

(Taken from Multidimensional Inventory of Black Identity (MIBI)-  
Sellers, Rowley, Chavous, Shelton & Smith, 1997)

A8AW1. Overall, being Black doesn't have much to do with how I feel about myself

A8BW1. Being Black is important to my self esteem

A8CW1. My fate is tied to the fate of other Black people

A8DW1. Being Black is not important to my sense of what kind of person I am

A8EW1. I have a strong sense of belonging to other Black people

A8FW1. I have a strong sense of attachment to other Black people

A8GW1. Being Black is a reflection of who I am

A8HW1. Being Black is not a big part of my social relationships

A8IW1. I feel good about Black people as a group

A8JW1. I am happy that I am Black

A8KW1. I feel that Blacks have had a lot of achievements and made a lot of progress

A8LW1. I often regret that I am Black

A8MW1. I am proud to be Black

A8NW1. I feel that Black people have made worthwhile contributions to this society

A8OW1. Overall, other people think Blacks are good

A8PW1. On the whole, Black people are respected by others

A8QW1. Most think that Blacks are less successful than other groups

A8RW1. The larger society does not respect Blacks

A8SW1. On the whole, other groups view Blacks in a positive way

A8TW1. Society thinks Black people are valuable