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An Analysis of Factors That Affect African American Women with Mental Illness

Abstract

The purpose of this quantitative study was to analyze data related to factors that affect African American women with significant mental health issues. The 323 participants identified for this research study were formerly homeless, single adults (21 – 61 years of age) who resided in a non-profit operated housing facility in an urban setting of New York that provides mental health supportive housing and services. The archival data was gathered from an electronic data warehouse. The main focus of the data analysis for this research was based upon descriptive statistics used to summarize the reports and provide a clear picture of the barriers/factors experienced by African American women and what could be done to improve their lives. This research study revealed that African American women are disproportionately more likely to experience societal circumstances that increase their chances for developing mental illness, and they are less likely to utilize mental health services. African American women must be able to obtain services in a non-judgmental, safe, environment from providers that are sensitive, culturally competent, and willing to accommodate them in non-traditional manners. Further research in the area of the effectiveness of the services and engagement of the African American women is required.

Document Type

Dissertation

Degree Name

Doctor of Education (EdD)

Department

Executive Leadership

First Supervisor

Josephine Moffett

Second Supervisor

Stephen Draper

Subject Categories

Education

An Analysis of Factors That Affect African American Women with Mental Illness

By

Marguerite Brown

Submitted in partial fulfillment
of the requirements for the degree
Ed.D. in Executive Leadership

Supervised by

Dr. Josephine Moffett

Committee Member

Dr. Stephen Draper

Ralph C. Wilson, Jr. School of Education

St. John Fisher College

August 2017

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Dedication

My entire existence has been a true gift from God. Thank you Mom. To the most amazing women, remarkable men, family, friends that supported me, being my lighthouse in the midst of the fog, I am truly grateful. I am appreciative for the love, patience, tolerance, and support of my life partner. The unforgettable journey with my Saint John Fisher College family and team Summit is priceless and is another rung on my life's ladder. I acknowledge the non-believers and the critics who taught me invaluable, unforgettable lessons that fueled my ambitions and motivated me to excel. In the words of Maya Angelou, "Love recognizes no barriers. It jumps hurdles, leaps fences, penetrates walls, to arrive at its destination full of hope."

Biographical Sketch

Marguerite P. Brown is currently the Director of Operations at a not-for-profit organization. She has dedicated twenty plus years of service to the special needs community. She passionately performs a role as an educator for adult learners. Ms. Brown attended The College of New Rochelle from 1999 to 2002 and graduated with a Bachelor of Liberal Arts degree with a concentration in Psychology in 2002. She attended The School of Public Affairs at Baruch College from 2002 to 2004 and graduated with a Master's degree in Public Administration in 2004. She came to St. John Fisher College in the summer of 2015 and began doctoral studies in the Ed.D. Program in Executive Leadership. Ms. Brown pursued her research on the factors that affect African American women with mental illness under the direction of Dr. Josephine Moffett and Dr. Stephen Draper and received the Ed.D. Degree in 2017.

Abstract

The purpose of this quantitative study was to analyze data related to factors that affect African American women with significant mental health issues. The 323 participants identified for this research study were formerly homeless, single adults (21 – 61 years of age) who resided in a non-profit operated housing facility in an urban setting of New York that provides mental health supportive housing and services. The archival data was gathered from an electronic data warehouse. The main focus of the data analysis for this research was based upon descriptive statistics used to summarize the reports and provide a clear picture of the barriers/factors experienced by African American women and what could be done to improve their lives. This research study revealed that African American women are disproportionately more likely to experience societal circumstances that increase their chances for developing mental illness, and they are less likely to utilize mental health services. African American women must be able to obtain services in a non-judgmental, safe, environment from providers that are sensitive, culturally competent, and willing to accommodate them in non-traditional manners. Further research in the area of the effectiveness of the services and engagement of the African American women is required.

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Chapter 1: Introduction

Homelessness has been a long standing issue in New York City, NY. Over the past 18 years, there has been a significant increase in homelessness, due to the lack of affordable housing, the increase of unemployment, domestic violence, young adults aging out of foster care, and natural disasters. Along with homelessness, the issue of those who are diagnosed with mental illness must also be addressed. Being homeless can put people at risk for poor physical and mental health (National Alliance on Mental Illness, [NAMI], 2015). According to the Coalition for the Homeless (2015), many of New York City's single homeless adults have higher rates of serious mental illness, addiction disorders, and other severe health problems. NAMI (2015) also noted that the majority of street homeless individuals within NYC are living with mental illness.

In 1995, mental illness was a great problem in America. It was also determined to be an extremely expensive problem, as mental health patients occupied over half of the hospital beds within the country (Townley & Kloos, 2014). In New York State, the census of the psychiatric hospital system exceeded 93,000, which was recorded as the highest ever (Townley & Kloos, 2014). As psychiatrists and medical doctors began to experiment with and prescribe approved psychotropic medications, they noticed a great improvement in patient stabilization. In 1965, with the passage of Medicaid, the federal government excluded funding for psychiatric facilities that had more than 16 beds; which included state psychiatric hospitals (Townley & Kloos, 2014; Tsemberis & Eichenberg, 2000). This led to an increase in these state psychiatric facilities releasing

patients into the community to maintain a medication regimen with minimal supervision, if any at all (Townley & Kloos, 2014; Tsemberis & Eichenberg, 2000).

Supportive housing in New York has become the response to the need of the street homeless population living with mental illness (Center for Urban Community Services [CUCS], 2012). In 1981, the Callahan v. Carey decision required that New York provide emergency shelter for its homeless (CUCS, 2012). This decision also pushed for mental health funding. A study conducted using panel data on 193 countries between 2001 and 2011 found gaps in services for people who had been deinstitutionalized from psychiatric hospitals (Shen & Snowden, 2015). In response to the gap in services, federal and state funding programs began to appear for community outreach to the homeless mentally ill, as well as for the provision of mental health services in non-licensed facilities.

By prioritizing housing over hospitalization and social workers over psychiatrists, these new mental health programs offered highly cost effective alternatives to in-patient psychiatric care, while reaching a broader population. Nonprofit organizations took the lead to develop supportive housing programs with financial assistance from the federal, state, and city agencies. The funding for supportive housing has become the responsibility of the New York City Department of Housing Preservation and Development (HPD), through the McKinney-Vento Act (CUCS, 2012).

The U.S. Department of Health and Human Services (2015) reported that one of the most common mental disorders in the United States is major depressive disorder (MDD) (U.S. Department of Health and Human Services, 2015; World Health Organization [WHO], 2010). Major depression can impact all people, but it is an

enormous health concern for women—particularly African American women (Bell, 1980; Cheng & Robinson, 2013; Crenshaw, 1988). According to a United States Census Bureau (U.S. Census) 2016 report, by the end of 2015, there were approximately 322 million people living in the United States and 42 million, or 13.2 %, identified themselves as Black or African American. Of that 13.2%, 16%, or 6.8 million African Americans were diagnosed with a mental illness (U.S. Census, 2015). African Americans experience major depression at higher rates than Whites; and Black women, in turn, also experience higher rates of depression compared to the general population (Pratt & Brody, 2008; U.S. Department of Health and Human Services, 2015; WHO, 2010).

African Americans face a number of barriers in the recognition and treatment of major depression including clinical presentation with somatization (the presence of physical bodily complaints in the absence of any medical condition), lack of comprehensive primary care, problems with the physician-patient relationships, competing clinical demands of comorbid (the presence of two or more disorders), general medical problems, and stigma about diagnosis (Smith, 2015; Snowden, 2012). African Americans who have depression may frequently be underdiagnosed and inadequately managed in primary care as a result of physician-patient relationships and treatment settings (Smith, 2015). Understanding how to overcome such barriers to the treatment of depressive disorders in African American patients is a way of assisting family physicians in better serving this population (Sosulski & Woodward, 2013). Creswell (2014) stated that research inquiry is related to both politics and a political change agenda to challenge social oppression wherever it occurs.

The history of mental health in the African American community is an intimately connected history that can be interpreted as a survival mechanism with race as a contributing factor (Logan, Denby, & Gibson, 2007; McNeil & Kennedy, 1997). Historically, African Americans, who entered the United States unwillingly as slaves, differ from immigrant groups who came freely in seek of better lives. In addition, African Americans were subject to denigrating and dehumanizing physical and social systems that governed their behaviors during the slave era (Logan et al., 2007; McNeil & Kennedy, 1997). “The history of African Americans and their mental health needs is a difficult history indeed. Many scholars and researchers would argue that the social and psychological ills that African Americans faced are directly related to various historical aspects of slavery” (Logan et al., 2007, p. 3). A further look at the historical perspective of mental health in the African American community can be found in Chapter 2.

Due to cultural and ethnic backgrounds, depression may be displayed differently among African Americans. The stigma and mythologies that surround depression generate unnecessary pain and misperception, and they can prevent people from getting appropriate treatment (Logan et al., 2007; McNeil & Kennedy, 1997). The following statements reflect some common misconceptions about African Americans and depression:

Why are you depressed? If our people could make it through slavery, we can make it through anything. When a black woman suffers from a mental disorder, the opinion is that she is weak. And weakness in black women is intolerable. You should take your troubles to Jesus, not some stranger/psychiatrist. (Mental Health America, 2013, para. 4)

The truth is that getting help is a sign of strength. People with depression cannot just *snap out of it*. Also, spiritual support can be a significant part of healing, but the care of a qualified mental health professional is essential. The earlier treatment begins, the more effective it can be. The eventual cost of being a strong Black woman may be depression, which is characterized as a silencing of a range of her human needs (Logan et al., 2007; McNeil & Kennedy, 1997; Nemade, Reiss, & Dombeck, 2007).

Throughout the ages, healers, philosophers, and writers have documented and emphasized the long-standing existence of depression as a health problem, and mental health practitioners have historically struggled to find effective ways to treat depression (Nemade et al., 2007).

Depression was initially called *melancholia* and was thought to be a spiritual (or mental) illness, rather than a physical one. It was thought that depression was an inherited, unchangeable weakness of temperament, which led to the common thought that affected people should be shunned or locked up. As a result, most people with mental illnesses became homeless and poor, and some were committed to institutions. (Nemade et al., 2007, p. 2)

Depression can be triggered by mental and physical causes at the same time, and it is no longer necessary to choose a single cause to account for all varieties of depression (American Psychiatric Association, 2013; Nemade et al., 2007). According to the *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (American Psychiatric Association, 2013), depression is defined as a mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder (MDD) or clinical depression (CD), it affects how a person may feel, think, and behave, and it can

lead to a variety of emotional and physical problems (American Psychiatric Association, 2013). Further explanation of MDD is located in the definition of terms section in this chapter.

Depression is frequently undetected, underdiagnosed, underreported, and undertreated among African Americans, and only 7% of African American women will receive some type of mental health treatment (Martin, Boadi, Fernandes, Watt, & Robinson-Wood, 2013). Because it has become the accepted view that depression frequently has multiple sources including (a) biological, (b) psychological, and (c) social causes, it has also become the norm that multiple professions and approaches to treatment have important roles to play. For example, different approaches to address the treatment of depression are needed to assist people with identifying the underlying causes of their depression (American Psychiatric Association, 2013; Nemade et al., 2007; U.S. Department of Health and Human Services, 2015).

When discussing the barriers to mental health services related specifically to African American women with depression, research has identified five major factors: (a) race, (b) stigma, (c) culture, (d) five dimensions of access (accessibility, affordability, availability, accommodation, and acceptability), and (e) underutilization of counseling services (Saurman, 2015; Smith, 2015; Snowden, 2012). This may be due to a counselor's race and ethnicity, which may also be a barrier to African American women seeking mental health services, as it might influence the help-seeking behaviors of this population (Banks & Kohn-Wood, 2002; Saurman, 2015).

The population of the US has grown increasingly diverse; therefore, it is quite possible that a client will encounter a professional counselor who is of a different race

(Trahan & Lemberger, 2014). Through culture, people form and develop explanations of health and illnesses, and perceive and adapt their health messages (Kim, 2014).

Decisions about choosing health care providers, describing symptoms, considering treatment options, and monitoring treatment adherence are all influenced by culture. The importance of a mutual perspective between the client and the provider is supported by being culturally competent. Cultural competency lies with both the provider and the client. If the client has cultural self-awareness, knowledge, and the skills that can assist in the delivery of effective mental health services which are ethnically and culturally diverse, there is a significant likelihood of success (Kim, 2014).

The correlation between racial/ethnic differences in the diagnosis of, and the choice of treatment for depression can be significantly affected by cultural competence (Kim, 2014). In contrast to perceived racism, cultural competence can help to explain matters about interpersonal relationships between health care providers and patients in health care settings (Kim, 2014). In an effort to reduce health care disparities, training courses that focus on learning about different cultures are offered (Hunn & Craig, 2009). Kim (2014) posited that actual interventions that are culturally sensitive need to be studied and developed specifically for treating minorities.

Racism continues to have an impact on the mental health of African Americans, despite progress made over the years. “Racism can be defined as organized systems within societies that cause avoidable and unfair inequalities in power, resources, capacities and opportunities across racial or ethnic groups. Racism can manifest through beliefs, stereotypes, prejudices or discrimination” (Paradies et al., 2015, p. 2). Critical race theory (CRT) focuses on the empirical information of ethnic minorities and their

communities of origin with respect to race and race relations (Delgado & Stefancic, 2001).

Racism continues to be a defining factor in the mental health for African Americans. CRT is a framework that can be used to theorize, examine, and challenge the way race and racism covertly and overtly impact social structures and practices (Delgado & Stefancic, 2001).

Rollock and Gordon (2000) listed eight areas in mental health that are influenced by racism:

1. The identification and interpretation of deviance and distress.
2. Definitions of psychological symptoms including the causes and cures.
3. Explanation of the etiology of mental disorder and deficiency.
4. Mental health evaluations that are designed to showcase the needs of disadvantaged groups.
5. Mental health service delivery lacking providers who are culturally similar to clients.
6. Racism that affects the institutional structure so that programs are designed with the economically disadvantaged in mind.
7. Diverse populations have been understudied in research projects.
8. Training in mental health services ignores social context and oppressed populations. (p. 7-8)

Increased awareness to these eight areas of the mental health service delivery system are integral to developing and maintaining best practices. Attention to the historical details of how mental health in the African American community has been

regarded, portrayed, and hypothesized, is vital in supporting the renewed efforts of greater cultural sensitivity in treatment methods and practitioner approaches (Logan et al., 2007; McNeil & Kennedy, 1997; Rollock & Gordon, 2000).

Public health's tradition of defending social justice issues suggests that CRT can provide influential new tools for pointing out racial and ethical health disparities (Delgado & Stefancic, 2001; Smith, 2015). As defined by sociologist Goffman in 1963, stigma is a "spoiled identity" and is characterized as the awareness of the difference associated with undesirable behaviors, and it is a significant barrier to mental health services (Givens, Katz, Bellamy, & Holmes, 2007). In recent years, another group of researchers defined stigma as a social process by which people or groups are deemed unwanted or unwelcomed due to physical, social, or psychological qualities, and they are subsequently left out or avoided by the mainstream group (Webb et al., 2016).

African Americans and White mental health consumers point to stigma as a serious barrier to help-seeking behaviors for mental health issues, and it is probably why Blacks are less likely (10.5%) than Whites (20.8%) to participate in mental health treatment (Agency for Healthcare Research and Quality, 2012; Menke & Flynn, 2009; Sosulski & Woodward, 2013). However, little has been done to ensure equity in mental health care in the African American community (Hunn & Craig, 2009; Sosulski & Woodward, 2013). One way to remediate the disparities in mental health services is to promote the inclusion of social justice and advocacy strategies to the role of mental health practitioners (Smith, 2015).

Individuals with mental illness have often adapted stigmatizing attitudes, self-stigma, or internalized stigmatization as it relates to themselves, which may exasperate

the course of the mental illness and, in turn, contribute to the public's negative perception of a person with MDD (Givens et al., 2007; Webb et al., 2016). In some cases, many people in the African American community misunderstand what a mental health condition is, and they may refuse to discuss the topic (Warren et al., 2010). This lack of knowledge leads many to believe that it is some sort of punishment from God or a personal weakness, and patients are reluctant to seek treatment services due to the stigma associated with mental illness (Hunn & Craig, 2009).

Also adding to the culture of stigma, is the image of the *strong Black woman* that disinclines Black women to show vulnerability (Okeke, 2013). While Black women have renounced the images socially constructed of Black womanhood, the representations of themselves still convey built-in capacities to deal with all manners of hardship without breaking down, physically or mentally. "You have to show strength . . . you need to be strong" (Okeke, 2013, p. 7). The Black woman is described as being compassionate, caring, understanding, and willing to help. Black women often feel as though, if she does not take care of herself, no one else will; this epitomizes her feelings of mistrust (Okeke, 2013).

The term, *Sisterella complex* was coined by two Black authors, Jones and Shorter-Gooden, (2009) to dramatize the capacity of the strength discourse to mask a loss of self under extreme other directedness: "Sisterella suffers quietly If you're trying to identify depression in Black women, one of the first things to look for is a woman who is working very hard and seems disconnected from her own needs" (Logan et al., 2007, p. 3). The Sisterella complex is a constellation of depressive symptoms that have been described using the following terms – unable to relax, works very hard (jobs tasks,

household, child care) and is disconnected from one's own personal needs, suffers quietly, experiences excessive guilt, feels worthless and unworthy (Logan et al., 2007).

The individual risk factors that may contribute to unmet health needs have been studied and associated with access barriers. These barriers include but are not limited to transportation problems, work/family responsibilities, lack of child care, office/clinic hours not conducive to patient's schedule, and not being able to choose their preferred provider. The socioeconomic status of this population varies and, in some cases, researchers indicate that it is a significant factor regarding mental illness and access to mental health services (Copeland & Butler, 2007; Shippee, Call, Weber, & Beebe, 2012).

In the African American community, family, community, and spiritual beliefs tend to be great sources of strength and support. However, research has found that many African Americans rely on faith, family, and social communities for emotional support rather than turning to health care professionals—even though medical and/or therapeutic treatment may be necessary (Hunn & Craig, 2009). “As the social work profession developed, African American social workers continued to develop culturally relevant approaches to addressing the needs of the African American community that encompasses holistic approaches rooted in the Black church traditions” (Brice & Hardy, 2015, p. 277).

Faith and spirituality can really help in the recovery process from mental illness, but researchers have expressed that it should not be the only option that is pursued (Brice & Hardy, 2015; Hardy, 2013; Hunn & Craig, 2009). If spirituality is an important part of life, spiritual practices can be a strong part of one's treatment plan. The spiritual leaders and faith community can provide support and reduce isolation. Faith-based communities

can be a source of distress and stigma if they are misinformed about mental health or do not know how to support families dealing with these conditions (Brice & Hardy, 2015; Hardy, 2013; Hunn & Craig, 2009). The Black Church is often the preferred resource for mental health services among African Americans (Brice & Hardy, 2015; Hardy, 2013).

Since 1997, the homeless population has increased due to the lack of affordable housing, increased unemployment, domestic violence, substance abuse, aging out of foster care, and natural disasters. African American and Latino New Yorkers are disproportionately affected by homelessness. Approximately 58% of New York City's homeless shelter residents are African American, 31% are Latin American, 7% are White, less than 1% are Asian American, and 3% are of unknown race/ethnicity (Coalition for the Homeless, 2015; CUCS, 2012).

Post World War II, commercial single-room occupancy (SROs) became popular dwellings for New York's poor. These SROs provided housing for single adults and families that could not afford regular rent, due to their limited income. These SROs also became a place for many individuals with mental illness to seek housing (Ridgway & Rapp, 1998).

Permanent supportive housing was established in New York City in the 1980s, and has now proven to be a successful and cost-effective solution to the homelessness crisis (Tompsett, Toro, Guzicki, Manrique, & Zatakia, 2006). The supportive housing model combines affordable housing assistance with essential support services for individuals living with mental illness, HIV/AIDS, or other serious health problems. Numerous research studies have shown that permanent supportive housing costs less than other forms of emergency and institutional care (Coalition for the Homeless, 2015;

Tompsett et al., 2006). The Federal Housing Association (FHA) is committed to making affordable housing available to qualified individuals and families (Coalition for the Homeless, 2015). The FHA approves non-profits for government funding to provide affordable housing, and the Department of Health and Mental Hygiene, the Office of Mental Health, and other entities provide funding for services for the individuals that reside in these affordable housing units (Coalition for the Homeless, 2015).

Problem Statement

Although race remains intertwined in public health in a variety of ways, the field's theoretical and methodological agreements inadequately address the complexity with which structural racism influences both health and the production of knowledge about this population's health and health disparities (Ford & Airhihenbuwa, 2010). The problem is that African American women who seek out mental health treatment services when diagnosed with a mental condition are faced with multiple barriers to those services. One in three African American women diagnosed with depression seek help; they lag significantly behind White American women who are diagnosed and seek help more frequently (Campbell & Long, 2014; NIMH, 2015). Researchers suggest that there are cultural biases against mental health and health care professionals in general, that prevent this population from accessing care due to prior historical experiences of misdiagnosis, inadequate treatment, and a lack of cultural understanding (National Alliance on Mental Illness – NYS [NAMI], 2015). The role of shaping beliefs, value and rule systems, problem-solving patterns, communication styles, and learned coping behaviors are all influenced by culture (Campbell & Long, 2014).

Cultural mistrust, stigma regarding mental illness, racism within the therapeutic exchange, and treatment modalities failing to address the cultural values and worldwide view of the client, have been identified as potential barriers to successful treatment for African Americans (Ojelade, McCray, Ashby, & Meyers, 2011). When defining and understanding the mental health of African American women, the intersection of race and gender, discrimination, and prejudice are paramount (Hunn & Craig, 2009). Culture is also crucial in recognizing and understanding the patterns of service use and the help-seeking behaviors among African Americans (Campbell & Long, 2014; Hunn & Craig, 2009). A person's mental health experience and behavior, can be viewed as social detriments of mental and behavioral health, especially when they are impacted by culture (Ford & Airhihenbuwa, 2010). Those non-medical factors that affect the health and well-being of people and communities are social detriments, which include, but are not limited to income, education, gender, and employment (Campbell & Long, 2014).

The use of service, consumer satisfaction, and system practice are three factors that influence consumers' access to the mental health system (Aday & Andersen, 1974; Saurman, 2015). Penchansky and Thomas introduced the theory of access in 1981; access was acknowledged as important in health care services, but in terms of research, was quite ambiguous (Saurman, 2015). These two researchers defined access as being situated between the consumer and the service, stating that the better the fit, the better the service (Saurman, 2015). Furthermore, both unmet need for, and fit of, primary medical services in a primary health care system, such as those provided by a family doctor, general practice physician, or nurse practitioner, have been associated with early detection of illness and disease, resulting in better mental and physical health outcomes

(Stam, Ford-Gilboe, & Regan, 2015). Moreover, patients who access mental health services in primary health care systems, such as those provided by counselors, social workers, psychologists, and psychiatric nurses, report significant improvements in depressive symptoms, anxiety, self-esteem, and quality of life over time (Stam et al., 2015; Snowden, 2012). Access is optimized in five dimensions:

- Accessibility,
- Availability,
- Acceptability,
- Affordability, and
- Adequacy or accommodation (Andersen, 1995; Saurman, 2015).

These dimensions are interconnected, yet they are independent, as each is paramount to the achievement of access (Andersen, 1995; Saurman, 2015). The dimensions of access address concerns to barriers and help to inform health care professionals on matters related to service design, assessment, implementation, and evaluation (Andersen, 1995; Campbell & Long, 2014; Saurman, 2015). Equating access with availability of resources will miss other characteristics of the provider and the clients that may be barriers to access (Andersen, 1995; Millman, 1993; Saurman, 2015). The mere presence of facilities is not an adequate measure of availability, it misses the more important issue of *goodness of fit* (Andersen, 1995; Millman, 1993; Saurman, 2015). Goodness of fit is described as the interaction between the characteristics of the provider and the expectations of the clients that regulate the adequacy of the resources (Andersen, 1995; Millman, 1993; Saurman, 2015).

Theoretical Rationale

The help-seeking behavior experiences of clients in counseling, particularly racial/ethnic minority clients, are the result of a profound influence of racialization (Trahan & Lemberger, 2014). Racialization is comprised of the processes of assigning ethnic or racial identities to a relationship, social practice, or group that does not identify itself as such. Identifying factors that affect the help-seeking behaviors of African American women can be an important step to reducing treatment stigma. Once these help-seeking behaviors are identified, they may help to individualize treatment plans in a manner consistent with the patient's preferences, and in consideration of the particular social pressures they experience (Givens et al., 2007).

The mistrust of authorities, many of whom are seen as not having the best interests of Black/African Americans in mind, have led to both historical and present-day instances of negative treatment (Trahan & Lemberger, 2014). There has been a decrease in the negative stereotypes and attitudes of rejection; however, they continue to occur with measurable and adverse consequences (Trahan & Lemberger, 2014). Non-African American mental health professionals are often unfamiliar with the symptoms that African American women display (Hunn & Craig, 2009). For example, African American women often present with physical symptoms that are characteristic of psychological distress that presents a biological problem (Hunn & Craig, 2009). Race-based exclusion from health, education, social, and economic resources are some historical adversities that translate into socioeconomic disparities experienced by African Americans today (Hunn & Craig, 2009; Trahan & Lemberger, 2014).

As a reaction against the critical legal studies (CLS) movement, due to the failure on the part of CLS to acknowledge how race is a central component to the very systems

of law being challenged, critical race theory originated in the field of law (Martinez, 2014). CRT was developed from the initial work of three scholars Bell (1980), Freeman (1988), and Delgado and Stefancic, (2001). These three legal scholars were discontent with the slow and ineffective success of racial reform of CLS, therefore CRT aggressively pursued the role that race and racism played in social inequality among dominant and marginalized racial groups in the United States (Rollock & Gillborn, 2011). Additionally, CRT was founded as a response to the civil rights movement in the 1950s and 1960s that stalled in the United States, especially after the deaths of Malcolm X, Martin Luther King, Jr., President John F. Kennedy, and Robert F. Kennedy. CRT differs from CLS in that it has an activist aspect, with an end goal that is to bring about change that can be implemented in social justice (Crenshaw, 1995).

CRT was developed as a legal framework to address race, racism, and societal inequalities faced by African Americans. It is based on the understanding that race and racism are incidences of racial inequality in society. By examining institutional operations and structures, critical race theorists expose implicit ways that maintain racial inequality (Rollock & Gillborn, 2011). CRT, specifically, involves five tenets or beliefs that are essential components to the theory: counter storytelling, racism's permanence, whiteness as property, interest conversion, and the critique of liberalism (Crenshaw, 1988).

Because of the discreet manner in which racism is portrayed, CRT theorists note that manifestations of racism are more difficult to recognize (Crenshaw, 1995; Trahan & Lemberger, 2014). CRT allows people to hear each other's voices and become empowered participants (Crenshaw, 1995). CRT is a way to theorize and challenge the

ways race and racism impact society and declare that the omnipresence of racism encompasses all people and experiences (Trahan & Lemberger, 2014). The mere symbolic occurrences of the counselor-client relationship embodying racial differences influences the therapeutic relationship, even though counselors might be operating in accordance with suggested cultural sensitivity models (i.e., multicultural counseling competencies and multicultural ethical decision-making models) (Trahan & Lemberger, 2014).

Although CRT can be puzzling and even disarming for professional counselors, when presented effectively, it can be an important tool to demonstrate the inter-centricity of race. Moreover, CRT can be used to introduce and train counselors in ethical decision-making processes and social justice behaviors. “To this end, the following three selected CRT tenets, *interest convergence*, *ordinariness of racism*, and *narrative storytelling*, can be used as strategies to engage counselors in honest conversations about racism with African American clients” (Trahan & Lemberger, 2014, p. 116).

Interest convergence asserts that all forms of racism advance the interest of Whites (Bell, 1980). Bell (1980) stated that Whites will only support social justice to the point that it benefits them, even when that change seems to help racialized minorities. This is why only 9% of African Americans feel that they are treated equally. Within the African American community, the existence of racism and discrimination has produced a variety of defense and survival mechanisms (Trahan & Lemberger, 2014). In the first few counseling sessions, African American clients may demonstrate reservations when faced with their perceived oppressor (i.e., the White counselor) (Trahan & Lemberger, 2014). Rather than choosing to refer the client to someone else because of their inability

to establish a rapport, it is imperative that the counselor consider the client's worldview (Trahan. & Lemberger, 2014). "White counselors need to be cognizant of how their racial identity may affect racially marginalized clients, potentially causing African American clients to be resistant during their initial stages of their counseling process" (Trahan & Lemberger, 2014, p. 116).

Ordinariness of racism suggests that racism always exists and it exists in all social structures in Western society, and actions intended to eradicate racism only reinforce the most noticeable and superficial forms of racism (Trahan & Lemberger, 2014). This purports that a colorblind ideology declares that racism has changed when, in fact, this notion spreads blatant forms of discrimination (Trahan & Lemberger, 2014). This tenet of ordinariness of racism can be used as a means to address the personal and interpersonal aspects of cross-cultural learning between the counselor and client. The client's self-identification (i.e., ethnic/racial identity, sexual orientation, religion) can be one of the most important characteristics to explore during therapy, and counselors should allow sufficient time for processing (Hunn & Craig, 2009; Sosulski & Woodward, 2013; Trahan & Lemberger, 2014). Exploring these differences openly is likely to enhance the therapeutic relationship (Trahan & Lemberger, 2014). Counselors can use this tenet to reflect on both their own bias and that of their clients, and those who are advocates for multiculturalism are not exempt from deeply embedded racial/ethnic biases (Trahan & Lemberger, 2014). In order to strengthen the rapport and decrease the likelihood of clients terminating treatment permanently, self-disclosure can be beneficial (Trahan & Lemberger, 2014).

Narrative storytelling is a form of expression that is used by racial/ethnic minorities; which is encouraged by CRT theorists when describing their experiences with racism (Delgado & Stefancic, 2001; Lynn & Dixon, 2013). Narratives are frequently used in the African American community and this tenet would provide counselors with a detailed understanding of the client's worldview as it relates to previous encounters with racial inequalities (Hunn & Craig, 2009; Trahan & Lemberger, 20104). Narratives can assist counselors with selecting help-seeking strategies that are appropriated based on the African American client's worldview, and they can empower clients to articulate how racism has affected them. A client's culturally learned patterns of communicating (both verbal and nonverbal) can be misinterpreted, along with a client's defensive nature, however, it can be better understood through narrative storytelling (Sosulski & Woodward, 2013; Trahan & Lemberger, 2014).

Racialization is the act of treating a person, a group, or a relationship in racial terms or as a race. For example, people can be sorted by the color of their skin and labeled lazy or unintelligent. Historically, this has allowed people to justify the inconsistency about the way other people are treated. Hoyt, a professor at Wheelock College in Boston, Massachusetts provided a simple example of this phenomenon by holding up three glasses and table-sized salt shakers. He filled each with a different substance: one with white salt, one with brown sugar, and one with white sugar. Holding the three shakers together with both white substances on each end, at first glance, when asked which two were alike, the answer would be the two white shakers. However, when told that the response was incorrect, the viewer would then see that the contents of the shakers were each quite different. As cognitive thinkers about race, often times the brain

is used to seeing things that are not there and running with it. When we talk about race, we often attach deeper meaning to surface distinctions. Identifying factors that affect the help-seeking behaviors of African American women can be an important step to reducing treatment stigma and racism, and it may help to individualize treatment plans in a manner consistent with the patient's social pressures and preferences (Givens et al., 2007).

In addition to providing effective methods of treatment, understanding the reasons why many people with depression do not seek help is the key challenge to improving access to mental health services (Saurman, 2015; Sosulski & Woodward, 2013).

Andersen's behavioral model of health services utilization was developed in the 1960s, and it is another theoretical framework that is used to reveal conditions that hinder the use of health services by African American women. The original model was developed by Andersen in 1968, a professor of Health Services at UCLA. It was designed to focus on the family as a unit of analysis, because he believed that the medical care that a family receives is a function of the demographic, social, and economic characteristics of the entire family unit (Andersen, 1995). This model has proven to be a valuable tool to select, identify, and sequence the relevant variables in the process of health services (Andersen, 1995).

Andersen's (1995) model has been modified several times over the past 40 years; however, the overall framework is consistent with the existing knowledge of barriers to access and utilization of mental health services by African American women. It is also used to assist in the arrangement of potential barriers (Andersen, 1995; Copeland & Butler, 2007). Figure 1.1 illustrates Andersen's behavioral model of health services

utilization, providing an understanding of the behaviors of consumers that also assist with federal spending on health care.

An important concept in health policy and health services research is access, yet it is not clearly defined. In 1981, Penchansky and Thomas surmised that access is presented as a general concept that outlines a set of dimensions that connect the patient to the health care system. The specific dimensions are availability, accessibility, accommodation, affordability, and acceptability (Copeland & Butler, 2007; Saurman, 2015). Pre-disposing factors, enabling factors, and need are the three dynamics that determine the usage of health care services.

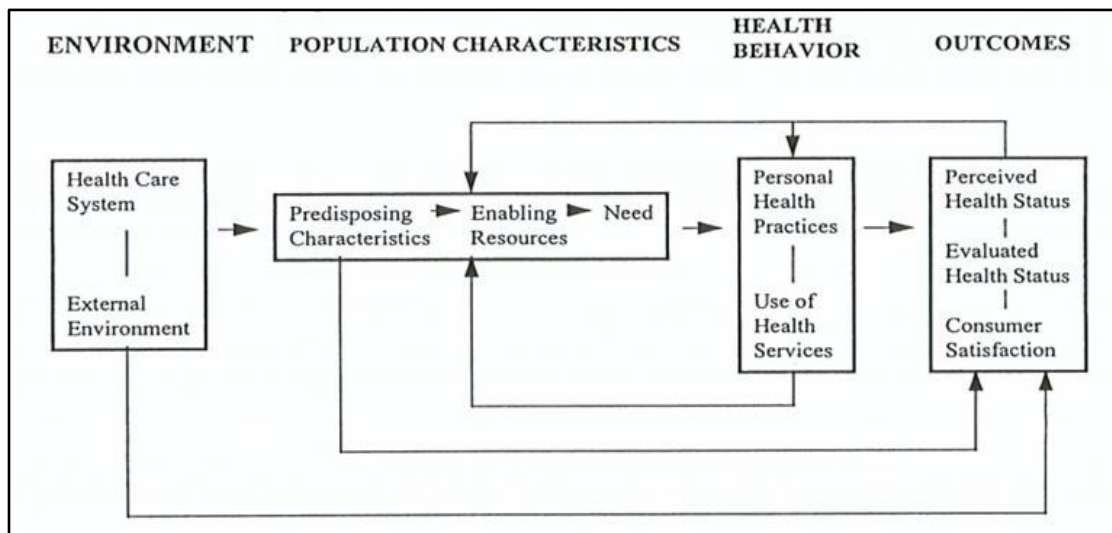


Figure 1.1. Andersen’s Behavioral Model of Health Services Utilization: An Emerging Model. Adapted from “Revisiting the Behavioral Model and Access to Medical Care: Does It Matter?” by R. A. Andersen, 1995, *Journal of Health and Social Behavior*, 36, p. 8. Copyright 1995 by Sage Publishing.

Individuals are more likely to seek care if they believe that the health care services are an effective treatment. Family supports, access to health insurance, and other

social connections are examples of enabling behavior. Finally, both perceived and actual need for health care services represents need. The development of Anderson's model was to offer measures of access. This framework makes a distinction between equitable and inequitable access. Equitable access is driven by demographic characteristics and need, whereas inequitable access is the result of enabling resources, health beliefs, and social structure (Andersen, 1995; Saurman, 2015).

Statement of Purpose

Anyone can develop a mental health problem; however, more severe forms of mental health conditions are sometimes experienced by African Americans, which is due to various barriers to accessing care (Greenwood, Habibi, Smith, & Manthorpe, 2014). Many researchers indicate that there is a lack of sufficient and adequate research on African Americans, which contributes to the problem of misdiagnoses, underdiagnoses, and under treatment of depression in African Americans, especially African American women (Carrington, 2006; Copeland & Butler, 2007; Quimby, 2006; Snowden, 2003). Subsequent studies have revealed that this need is currently quite prevalent (Campbell & Long, 2014; Smith, 2015; Snowden, 2012; Warren et al., 2010).

Mental health and well-being are influenced not only by individual attributes, but also by social circumstances in which people find themselves and the environment where they live (WHO, 2012). Risk factors to mental health manifest themselves at all stages in life; these determinants interact with others strongly and may threaten or protect an individuals' mental health state (WHO, 2012).

The purpose of this study is to analyze the factors that affect formerly homeless African American women compared to White and Latino women with mental illness who

receive mental health support services in an identified non-profit housing facility in New York City. This researcher currently serves as an analyst responsible for monitoring program performance in accordance to federal and state regulatory agency requirements to ensure continued funding for mental health support services. For the purpose of this study, this researcher was interested in understanding if support service utilization is effective, specifically for African American women between the ages of 21 and 65 years of age, with mental health issues, as compared to other women. This quantitative study of archival data (from January 2014 to December 2015) analyzed the age, race, gender, diagnosis, level of education, and length of stay of this target population within a mental health supportive, services housing program. A more comprehensive understanding of the mental health service utilization of African American women provides a platform for advocacy for equitable access to quality services and resources by insisting on institutional and societal change within the mental health industry (Smith, 2015). This is discussed further in Chapter 5.

Research Questions

This research study used a quantitative design that analyzed archival data to determine whether or not there was a significant difference in single, African American women with significant mental illnesses receiving mental health support services at various ages. Penchansky and Thomas (1981) conceived access as the fit between the characteristics and expectations of the providers and the clients. These dimensions are grouped into the five “A”s of access to care: (a) affordability, (b) availability, (c) accessibility, (d) adequacy or accommodation, and (d) acceptability (Andersen, 1995; Penchansky & Thomas, 1981; Saurman, 2015).

Affordability is determined by how the providers' charges relate to the client's ability and willingness to pay for services (Andersen, 1995; Penchansky & Thomas, 1981). As it relates to the target population for this research study, all the participants were eligible for services based upon their residency in the mental health supported housing program. Availability measures the degree to which the provider has the essential resources, such as personnel and technology, to meet the needs of the client (Andersen, 1995; Penchansky & Thomas, 1981). The mental health support services are provided on site and off site at community-based mental health facilities. However, participation is a choice, it is not mandatory. Accommodations reflect the extent to which the providers' operation is structured in ways that meet the limitations and preferences of the clients. Of greatest concern are the hours of operation, how telephone communications are handled, and the clients' ability to receive care without a prior appointment (Andersen, 1995; Penchansky & Thomas, 1981). Accessibility refers to geographic convenience, which is determined by how easily the client can physically reach the provider's location (Andersen, 1995; Penchansky & Thomas, 1981). Based upon the fact that the mental health support service programs are designed to have on-site social workers and case management, some of the services are provided at alternate locations, however, these services are voluntary and accessibility is not measured in this study. To conclude, of the five "A's," acceptability captures the extent to which the client is comfortable with the more immutable characteristics of the provider, and vice versa (Andersen, 1995; Penchansky & Thomas, 1981). These characteristics include age, sex, social class, and ethnicity of the provider (and of the client), as well as the diagnosis and type of insurance coverage of the client (Andersen, 1995; Penchansky & Thomas,

1981; Saurman, 2015). It should be noted that all mental health participants in this research were eligible for federal Medicaid to pay for their medical and psychiatric treatment.

The research questions that guided this dissertation study were designed to analyze factors that may affect African American women with mental illness that receive supportive mental health services in a housing program of a not-for-profit organization;

1. Is there a significant difference in the mean age by gender of the individuals receiving mental health supportive services?
 - a. Null Hypothesis (HO1 - a): There is no significant difference in the mean age by gender of the individuals receiving mental health supportive services.
 - b. Alternative Hypothesis (AH1 - b): There is a significant difference in the mean age by gender of individuals receiving mental health supportive services.
2. Is there a significant difference in the mean age of the women receiving mental health supportive services by race?
 - a. Null Hypothesis (HO2 - a): There is no significant difference in the mean age of women receiving mental health supportive services by race; in African American women versus Latin American women versus White women.
 - b. Alternate Hypothesis (AH2 - b): There is a significant difference in the mean age of women receiving mental health supportive services by race; in African American women, versus Latin American women versus White women.

3. Is there a significant difference in diagnosis by race of women receiving mental health supportive services?
 - a. Null Hypothesis (HO3 - a): There is no significant difference in the diagnosis of a significant mental illness in African American women versus Latin American women versus White women receiving mental health supportive services.
 - b. Alternate Hypothesis (AH3 - b): There is a significant difference in the diagnosis of a significant mental illness in African American women versus Latin American women versus White women receiving mental health supportive services.

Significance of the Study

Clinical practice relies on mental health research, primarily investigations driven by their capacity for statistical analysis (Copeland & Butler, 2007; George, Duran, & Norris, 2014; Ross et al., 2015; Quimby, 2006). According to a report published by NAMI (2015), only about one-quarter of African Americans seek mental health care, compared to 40% of Whites (Campbell & Long, 2014; Sosulski & Woodward, 2013). Historically, African Americans have been negatively affected by prejudice and discrimination in the health care system, and this continues to be (Cheng & Robinson, 2013; Hunn & Craig, 2009; Nicolaidis et al., 2010; Paradies et al., 2015; Smith, 2015; Warren et al., 2010). Misdiagnoses, inadequate treatment, and lack of cultural competence by health professionals breed distrust and prevents many African Americans from seeking or staying in treatment (Ojelade et al., 2011; Smith, 2015; Snowden, 2003, 2012; U. S. Department of Health and Human Services, 2015).

Another factor in not seeking medical care is the lack of African American mental health professionals who are culturally competent (Copeland & Butler, 2007; Hunn & Craig, 2009; Paradies et al., 2015; Smith, 2015; Waheed, Hughes-Morley, Woodham, Allen, & Bower, 2015). Only 3.7% of the members in the American *Psychiatric* Association and 1.5% of members in the American *Psychological* Association are African American (U. S. Department of Health and Human Services, 2015). Smith (2015) stated that the mental health profession must vigorously challenge social policies or practices that threaten the emotional, social, and psychological well-being of the African American community and other racial and ethnic groups, as well as diverse groups created by intersecting cultural identities.

Definitions of Terms

Bipolar disorder – According to the American Psychological Association (2017a), bipolar disorder is,

a serious mental illness in which common emotions become intensely and often unpredictably magnified. Individuals with bipolar disorder can quickly swing from extremes of happiness, energy and clarity to sadness, fatigue and confusion. These shifts can be so devastating that individuals may choose suicide. All people with bipolar disorder have manic episodes — abnormally elevated or irritable moods that last at least a week and impair functioning. But not all become depressed. (American Psychological Association, 2017a, para. 1)

Critical race theory (CRT) – a theoretical framework in the social sciences that is focused on a critical examination of society and culture, to the connection of race, law, and power.

Depression – According to the American Psychological Association (2017b) depression is,

more than just sadness. People with depression may experience a lack of interest and pleasure in daily activities, significant weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, feelings of worthlessness or excessive guilt and recurrent thoughts of death or suicide.

Depression is the most common mental disorder. Fortunately, depression is treatable. A combination of therapy and antidepressant medication can help ensure recovery. (American Psychological Association, 2017b, para. 1)

Major depressive disorder (MDD) – a depressed mood or a loss of interest or pleasure in daily activities for more than 2 weeks.

Mental health support services – housing and case management services provided in an urban non-profit permanent (single-room occupancy) housing facility for formerly homeless single women between the ages of 21. The services range from case management, education/vocational, medication management, entitlement assistance, and referrals to other community based professional services, based on necessity.

Schizophrenia – is a “a serious mental illness characterized by incoherent or illogical thoughts, bizarre behavior and speech, and delusions or hallucinations, such as hearing voices. Schizophrenia typically begins in early adulthood” (American Psychological Association, 2017c, para. 1).

Chapter Summary

The intersection of history, defining depression, exploring the various barriers that African American women exhibit regarding their distrust of the mental health

practitioners and other service providers, all provide a platform for research. Explaining the significant role that culture, race, and stigma have on both the provider and the patient offers clear insight into the challenges that African American women encounter when seeking mental health services. Mental health and socioeconomic status is linked. Depressive symptoms can be explained by cultural and socioeconomic factors, but it is unclear whether racial disparities can be explained (Nicolaidis et al., 2010). While numerous barriers to mental health treatment exist, the stigma of mental illness remains a particularly relevant factor influencing mental health treatment (Sickel, Seacat, & Nabors, 2014).

It is understood that critical race theory is a notion of social change. Researchers who seek to utilize CRT are cautioned to consider how their learning aids in the project of social justice and social change are affected (Delgado & Stefancic, 2001). Policy makers have historically undervalued patient experience. “Nevertheless, a rapidly accumulating body of evidence makes clear that any sound strategy for broadening and strengthening incentives for clinicians must give priority to the patient experience” (Marriott, 2011, p. 5). Patient experience has recently been recognized as a cornerstone of improved health care that is distinct from other aspects of quality, as enunciated in influential reports from the Institute of Medicine, the Institute of Healthcare Improvement’s “triple aim,” and the Measure Application Partnership (Schlesinger, Grob, & Shaller, 2015, p. 2123).

Additional examination that is able to highlight these distinctions and problematize *race* and *culture* in research will improve the ways in which policies and services are developed to assist African American women in their access to and success

in mental health treatment. The results from the National Survey of American Life examining 12-month mental health service use concluded that, “the underuse of mental health services among Black Americans remains a serious concern. Educational interventions that focus on both consumers and mental health care professionals are needed” (Neighbors et al., 2007).

This research study has five chapters. The first chapter reviewed the research problem, the purpose of the study, the research questions, and the potential significance of a study examining the characters of African American women with mental illnesses who reside in a supportive housing setting. The chapter concludes with the definitions of terms pertinent to this study. A review of the literature on various studies that have been conducted highlighting the barriers to obtaining services and the characteristics of the women affected is presented in Chapter 2. The research design, methodology, and analysis is discussed in Chapter 3. Chapter 4 presents a detailed analysis of the results and findings, and Chapter 5 discusses the findings, implications, and recommendations for future research and practice.

Chapter 2: Review of the Literature

Introduction and Purpose

According to the 2015 United States Census, the population at that time was approximately 315 million; 13.2 % of the U.S. population identified as African Americans, and over 16% of those African Americans had a diagnosable mental illness (U.S. Census Bureau, 2015). However, this population is often the recipient of disproportionately lower quality of care than other communities for both mental health and medical care (NAMI, 2015; Snowden, 2012). It is unclear whether racial disparities can be explained by cultural or socioeconomic factors as it relates to major depression, however, there is ample evidence that suggests that African Americans are significantly less likely to receive appropriate mental health care than Whites (Nicolaidis et al., 2010). There has been research conducted all across the globe related to African American women with mental health disorders and the barriers to mental health services (Banks & Kohn-Wood, 2007; Poole, Smith, & Simpson, 2015; Quan, 2006; Warren et al., 2010); however, there remains an underutilization of services by the African American woman. These studies are related to their help-seeking behaviors, the specific factors that impact their behaviors, and the patterns of service for African American women with depression or bipolar disorder.

This review of the literature examined the factors that contribute to the underutilization of mental health services by African American women with mental health disorders and hinder African American women living healthy lives. Although

studies may differ about the impact of slavery on the mental health of African Americans, others espouse that this very denial impacts the mental health of African Americans as well as those who deny the connection (Logan et al., 2007; Snowden, 2012). For some African Americans, emotional stressors affect internal views and external behaviors that are compared to the behaviors of Whites (Logan et al., 2007). Historically, African Americans experienced racism, intolerance, exclusion from quality health care, limited economic resources, and detrimental experiences with health care research. Other influential factors included devaluation and mistreatment (Hunn & Craig, 2009; Logan et al., 2007; Smith, 2015; Snowden, 2012).

The stress of racism and discrimination has had a significant effect on African Americans. There are three major eras that have affected the African Americans' mental health. They are slavery, emancipation, and systemic issues unique to 20th century America (Logan et al., 2007; McNeil & Kennedy, 1997). The system was designed to oppress African Americans and slavery was a defining era. This history of mental health for African Americans has been called *shameful* and connected to the status of being free or being enslaved (Logan et al., 2007; McNeil & Kennedy, 1997; Whitaker & Hirst, 2002). The conditions of separation (from children, spouses, family), sexual abuse, physical and emotional abuse, poor living conditions, and severe poverty all contribute to the mental health of African Americans (Logan et al., 2007; McNeil & Kennedy, 1997; Whitaker & Hirst, 2002).

In psychiatry, dysaesthesia aethiopica was an alleged mental illness described by American physician Cartwright in 1851, who proposed a theory for the cause of laziness among slaves. Today, dysaesthesia aethiopica is considered an example of

pseudoscience, and part of the edifice of scientific racism. (Logan et al., 2007; McNeil & Kennedy, 1997; Whitaker & Hirst, 2002). The draptomania aethiopsis diagnosis was given to those seen as lazy and disrespectful (being destructive) of the master's property (Logan et al., 2007; McNeil & Kennedy, 1997; Whitaker & Hirst, 2002). The 1840 census indicated that there was a higher percentage of alleged insanity among slaves in the North, compared to their peers in the South (Logan et al., 2007; McNeil & Kennedy, 1997; Whitaker & Hirst, 2002). This was attributed to the increase of White slave owners telling census workers that all the Negroes in their communities were crazy; which began a social construct view of African Americans that eventually became fact and reason for mass institutionalization (Logan et al., 2007; Whitaker & Hirst, 2002).

During this era, Africans used self-help for aid with concerns in the form of the extended family, while the older slaves were afforded the status of being wise and were sought after for guidance (Hunn & Craig, 2009; Logan et al., 2007). Early African Americans used spirituality and the Black churches for emotional reprieve from their problems of oppression; which spread the misperception that African Americans lived a *trouble-free life* and they received special care and supervision under the institution of slavery (Hunn & Craig, 2009; Logan et al., 2007; Snowden, 2012). Although some may disagree about the influences of slavery on the mental health of African Americans, others espouse that this very denial influences the mental health of African Americans as well as those who deny the connection (Logan et al., 2007; McNeil & Kennedy, 1997; Whitaker & Hirst, 2002). Historically, African Americans experienced racism, intolerance, exclusion from quality health care, limited economic resources, and negative

experiences with health care research (Hunn & Craig, 2009; Logan et al., 2007; McNeil & Kennedy, 1997; Smith, 2015; Snowden, 2012; Whitaker & Hirst, 2002).

The emancipation of the slaves did not eradicate the problems that the African Americans encountered with mental health diagnoses. During this era, African Americans became at risk for being institutionalized in asylums because of the definition of sanity (Logan et al., 2007; Whitaker & Hirst, 2002). Sanity was defined by the behaviors that slave masters valued as a docile, hardworking laborer who paid him proper respect (Logan et al., 2007; Whitaker & Hirst, 2002). Those who avoided this behavior found themselves in asylums, jails, and the poor house. Whitaker and Hirst, (2002) documented that the occurrences of insanity for Blacks increased significantly during emancipation. Additionally, doctors continued to publish medical material that linked being Black with being insane and having limited intelligence (Logan et al., 2007; Whitaker & Hirst, 2002).

Fast forward to the 20th century when the mental health of Blacks during this era was characterized by inferior treatment and severe mental health diagnoses (Logan et al., 2007; Whitaker & Hirst, 2002). For example, African Americans were diagnosed with schizophrenia instead of depression (Logan et al., 2007; Whitaker & Hirst, 2002). The prevailing thought was that Blacks did not react to grief or remorse, and that they were all *happy go lucky* (Logan et al., 2007; Hunn & Craig, 2009; Whitaker & Hirst, 2002). However, by the 1930s research on African Americans began reporting that they had higher rates of insanity than Whites, which may have been an indication of racist diagnostic patterns in reaction to increased opposition to adversarial conditions

encountered by African Americans (Logan et al., 2007; Hunn & Craig, 2009; Whitaker & Hirst, 2002).

Interestingly, children from poor families were more likely to have mental health issues than those children from wealthier families (Hunn & Craig, 2009; Logan et al., 2007; Snowden, 2012). This seems to suggest that family poverty histories influenced children's mental health status (Hunn & Craig, 2009; Logan et al., 2007; Snowden, 2012). African American children were more likely to live in poverty than other children, so they were more likely to receive a mental health diagnosis than other children (Hunn & Craig, 2009; Logan et al., 2007; Snowden, 2012).

In the United States, there was an epidemic of children in poverty being placed in special education classes, because the tests that schools used to measure were based on whether these children knew middle-class language. The tests were designed to measure their experiences, various topics, vocabulary, sentences skills, and structure. If they failed they were considered not very bright. Educators began to see that the children's capacity to learn was based on what they had not been exposed to, thus the system began to change and be more inclusive (Enwefa, Enwefa, & Jennings, 2006).

While researchers continue to seek methods of engagement in order to illuminate the need for equity in the provision of mental health services for the African American women, there continues to be conflicting data related to the prevalence rate of mental illness in the African American community, compared to the general population and compared to White women. Despite equal or greater need, African American women are less likely than White women to use mental health care services (Carrington, 2006; Copeland & Butler, 2007). Some studies indicate significantly higher prevalence rates

and severity of mental illness (Copeland & Butler, 2007; NAMI, 2015; WHO, 2010), while other studies report lower rates in the African American community (Kessler et al., 2005; NAMI, 2015). It is important to highlight that while some research indicates that African Americans have a lower lifetime risk of mental illness, they are still more likely to be persistently mentally ill once diagnosed (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005).

Review of Literature

As the help-seeking behaviors of African American women are examined, there continues to be significant research with regard to the disparities in access to mental health services, particularly for this population (Greenwood et al., 2014; Hunn & Craig, 2009; Smith, 2015; Snowden, 2012; Sosulski & Woodward, 2013). The Surgeon General of the United States, Dr. David Satcher, released a *Culture, Race and Ethnicity 2005* report that documented the poor quality of mental health care and the lack of access that people of color with mental illnesses had been experiencing (Snowden, 2012). There were several subsequent reports issued related to this health care research, and they continued to highlight the myriad of barriers to accessing mental health services and the poor quality of care received by ethnic/racial communities of unequal treatment that was confronting racial and ethnic disparities in health care. (American Psychiatric Association, 2013; Carrington, 2006; NIMH, 2012).

In 2009, there was a significant difference in the health insurance coverage between African Americans and White Americans; 21% of White Americans had coverage, while only 15.8% of African Americans had any health insurance coverage (Cohen, Martinez & Zammitti, 2016). The lack of insurance coverage is considered a

barrier to mental health care, and disparities in access to mental health services are partly attributable to financial barriers. Snowden (2012) stated that better access to private coverage is an important step, and African American populations' dependence on public financing proposed that the provisions of the Medicaid programs are also important. Subsequent research conducted agreed with these reports, highlighting access as a significant factor to African American women obtaining mental health services (Aday & Andersen, 1974; Greenwood et al., 2014; Mynatt, Wicks, & Bolden, 2008; Snowden, 2012).

African Americans and White mental health consumers point to stigma as a serious barrier to seeking help for mental health problems, and it is probably why Blacks are less likely (10.5%) than Whites (20.8%) to participate in mental health treatment (Agency for Healthcare Research and Quality, 2012; Sosulski & Woodward, 2013). However, little has been done to ensure equity in mental health care in the African American community.

African Americans reported greater mental health stigma than their White counterparts (Menke & Flynn, 2009). In recent years, another group of researchers defined stigma as a social process by which people or groups are deemed unwanted or unwelcomed due to physical, social, or psychological qualities, and are subsequently left out or avoided by a mainstream group (Webb et al., 2016). The stigma surrounding a psychiatric diagnosis is a widespread and significant problem that is exhibited in numerous ways. It has led to reduced housing and employment opportunities, weakened social supports, and increased fear that the public has of those with mental illnesses (Webb et al., (2016). Individuals with mental illness have often adapted stigmatizing

attitudes, self-stigma, or internalized stigmatization as it relates to themselves, which may exasperate the course of the mental illness and, in turn, contributes to the public's perception (Givens et al., 2007; Webb et al., 2016).

Stigma also involves the *labeling* of a person with mental illness, categorizing *us* and *them* (Givens et al., 2007; Webb et al., 2016). This labeling has contributed to the redefining of mental health disorders, modifying diagnostic terms, and ultimately publishing upgraded versions of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM). For example, what was once termed as “manic depressive disorder” was renamed “bipolar disorder” in the third edition of the DSM-III. In the DSM-IV “depressive disorder,” “major depressive disorder,” “bipolar I,” and “bipolar II” were all defined differently with more specific psychotic features (American Psychiatric Association, 2013). The DSM-5 allows for the specification of particular conditions for other specified bipolar disorders, and it contains several new depressive disorders (Weaver, Himle, Taylor, Matusko, & Abelson, 2015; Webb et al., 2016).

Hunn and Craig (2014) stated that the most significant barriers to the treatment of mental health problems, particularly in the Black community, are access and stigma. Scholars have long debated stigma's effects on the psychological functioning of its targets, with some concluding that stigma does not harm self-esteem (Crocker & Major, 1989), and others taking the opposite stance. Duval and Wicklund (1972) proposed a resolution to this debate by applying the theory of objective self-awareness to the literature on the psychological consequences of stigma. Researchers have argued that public stigma has negative consequences when its targets focus objectively on their

stigmatized status (Duval & Wicklund, 1972, Snowden, 2012; Sosulski & Woodward, 2013).

The central theme of critical race theory is the idea that institutions often function based on values, principles, and foundations that are not culturally diverse or representative, regardless of racial make-up (Graham, Brown-Jeffy, Aronson, & Stephens, 2011). Racism can be demonstrated through stereotypes, prejudices, beliefs, or discrimination, and it encompasses everything from open threats and insults to phenomena deeply embedded in social systems and structures (Paradies et al., 2015). Racism can happen at numerous levels: internalized (the incorporation of racist attitudes, beliefs, or ideologies into one's worldview); interpersonal (interactions between individuals); and systemic (e.g., the racist control of, and access to labor, material, and symbolic resources within a society) (Carrington, 2012; Paradies et al., 2015).

Racism persists as a cause of elimination, conflict, and disadvantage on a worldwide scale, and existing statistics propose that racism is increasing in many national contexts (Paradies et al., 2015; Snowden, 2012). Racism can influence health via numerous known pathways: reduced access to employment, housing, and education and/or increased exposure to risk factors (e.g., avoidable contact with police); adverse cognitive/emotional processes and associated psychopathology; diminished participation in healthy behaviors (e.g., sleep and exercise) and/or increased engagement in unhealthy behaviors (e.g., alcohol consumption) either directly as stress coping, or indirectly, via reduced self-regulation; and/or physical injury as a result of racially motivated violence (Paradies et al., 2015; Snowden, 2012).

Individual situations or differing social circumstances may have potential sensitivity to prejudices (Kwate & Goodman, 2015). During the data collection process of a cross-sectional and longitudinal assessment of the mental health among residents in a Black neighborhood in New York City, the trial of George Zimmerman, the man who shot and killed Trayvon Martin – an unarmed Black youth, was also taking place in Florida. It was determined that the case had a significant impact and shaped the health responses to questions related to individual encounters with racism (Kwate & Goodman, 2015). “CRT insists that investigators be more honest and forthcoming regarding their subjective perspectives in design, data collection, interpretation, and the research endeavor as a whole” (Graham et al., 2014, p. 89). Critical race theory has evolved since its inception in the 1970s and has been used by numerous researchers, using both quantitative and qualitative methodologies. However, the theoretical lens of critical race theory emerges as the singular view that helps to shape the understanding of race.

Help-seeking and service use for depression among African Americans is culturally shaped on the notions that health and illness have a strong impact on how individuals engage (Campbell & Long, 2014). Researchers, Campbell and Long (2014), sought to identify culturally shaped beliefs that can be held by Black communities and to understand their impact on participants’ thoughts about depression and treatment as well as their attitudes about seeking help. It was discovered through qualitative interviews with 17 Black men and women that culturally shaped beliefs held in the Black community impede on service use and help-seeking behaviors (Campbell & Long, 2014). The three culturally shaped beliefs that were extracted from this study were: (a) Black people don’t get depressed, (b) I don’t trust the doctors and/or the treatment, and (c) you

don't need a doctor—it'll go away—just pray (Campbell & Long, 2014). Attending to these cultural factors and establishing interventions that take into account the importance of these factors can alter how research is conducted (Campbell & Long, 2014; Copeland & Butler, 2007; Leonardo, 2012).

In a similar study, researchers conducted a focus group study using a community-based, participatory-research approach with low-income African American women; 30 African American women participated in four focus groups. Their discussions revolved around the impact that violence, depression, and substance abuse had on their health, their perceptions of race as it related to health care, and mistrust of what they called the *White system* (Nicolaidis et al., 2010). A barrier to both recognizing depression and seeking care was the image of the “strong Black woman.” The women also expressed negative attitudes toward antidepressants. They expressed a fear of addiction, fear of being *doped up*, mistrust of prescribers, fear of adverse side effects, and a desire to cope on their own. The women wanted a community-based depression program staffed by African Americans that addressed substance abuse and violence (Nicolaidis et al., 2010).

At the conclusion of the study Nicolaidis et al. (2010) found that racism was the predominant issue influencing the participants' views on depressive care, in spite of their understanding that violence and drug use were central to their depression. Additionally, the study concluded that providers should develop a greater appreciation of the effect that racism has on care for depression (Nicolaidis et al., 2010). African American women's attitudes and feelings are prejudiced toward mental health providers due to their experiences, depending upon whether the experience was positive or negative (Copeland & Butler, 2007). African American women may seek more help as needed to advance

their progress toward recovery. If interventions are improved with increased awareness about culture and gender, then these issues may be alleviated (Sosulski & Woodward, 2013).

Mental health treatment coverage was strongly advocated for by the American Counseling Association (ACA) by identifying prevention, early intervention, and treatment of mental and/or substance use disorders as an essential health benefit (Smith, 2015). Psychotherapy or talk therapy, psychological assessments, and prescription assistance are all forms of mental health treatment. These services can be delivered in structured out-patient settings by agencies, partial hospitalization (day treatment programs), residential mental health treatment settings, and with in-patient hospitalization by a clinical team (counselors, psychologists, social workers) (Smith, 2015; Snowden, 2012; Sosulski & Woodward, 2013).

A group of researchers conducted a study of mental health and/or substance use issues associated with significant disparities in morbidity (illness) and mortality (death). The aim of the study was to identify the mechanisms underlying poor primary care access for this population. It was a community-based, participatory-action qualitative study in which 85 adults, who self-identified as having a serious mental health and/or substance use issues, and 17 service providers from various disciplines who worked with this population, participated in semi-structured interviews (Ross et al., 2015). Two primary barriers operating at the clients' level were; (a) socioeconomic barriers, and particularly those associated with poverty, unstable housing, and related barriers to access; and (b) barriers related to mental health experiences and side effects of the medications or other substances the client participants were using.

Participants also described systems-level barriers to accessing primary care that had unique and often substantial impacts on the people living with mental health and/or substance use issues. Particularly relevant barriers were: challenges in finding a regular family physician, having all health needs addressed in a timely manner, lack of availability of counseling/support groups, and barriers associated with models of primary care. The Ross et al. (2015) study identified the client, the service provider, and the health systems barriers to primary care access for people living with mental health and/or substance use issues. Interventions to address these identified barriers at the client, service provider, and health system levels should collectively improve the accessibility and quality of primary health care for individuals living with mental health and/or substance use issues, which in turn, may reduce associated disparities in morbidity and mortality (Ross et al., 2015).

On the other hand, one researcher, Robinson-Wood (2014), specifically spoke to the measured resistance of African American women to seek mental health services. The Resistance Modality Inventory (RMI) was utilized in a study of African American women to measure the theoretical construct of resistance (Robinson-Wood, 2014). The researcher stated that Black women endure many conditions related to economics, both physiological and psychological, based on race, gender, and class discrimination (Robinson-Wood, 2014). Within the intersecting relationships among these sources of oppression, Black women must be understood with multiple jeopardy, which refers to racism, sexism, and classism in their lives (Graham et al., 2011; Robinson-Wood, 2014).

The *no-show phenomenon* examines the reason African American females fail to keep scheduled appointments (medical or mental health). Researchers have indicated that

the no-show problem is acute in many urban mental health-care centers (Tidwell, 2004). In disagreement with RMI, 90 African American women participated in a study; 37 missed their mental health appointments, and 53 missed their medical appointments. The participants offered a myriad of reasons, which included forgetting their appointments, having child care issues, conflicts with school or work, transportation problems, court appearances, and other miscellaneous excuses (Tidwell, 2004). This exploratory study was one of the first studies to address the concept of resistance as it presents itself as no-show behavior (Tidwell, 2004).

The researcher suggested that further study should be conducted to address a larger pool of respondents to ascertain if the results provide evidence that no-show behavior will improve how African American women perceive mental health care and the quality of the mental health services (Tidwell, 2004). However, the Tidwell study does indicate that the patients do have some control over their access to mental health treatment services (Snowden 2012; Sosulski & Woodward, 2013). The individual characteristics of clinicians and researchers shape the way mental health services are provided and utilized within the cultural frameworks and social settings for African American women (Aday & Andersen, 1974; Quimby, 2006). It is crucial not to stereotype African American women when planning and implementing integrated mental health services (Quimby, 2006). Recognition of consumers' perspectives, not just the clinicians' viewpoints are required in order to sustain treatment (Quimby, 2006).

Bias occurs in the beliefs and actions of individual clinicians, and it is at this level that it has received the greatest amount of attention. Bias also occurs when unfounded assumptions become normative beliefs shared by members of

practitioner networks or treatment organizations. Bias occurs, too, when authorities and community members become particularly intolerant of minority individuals with mental illnesses and differentially enforce conformity norms of acceptable behaviors. (Snowden, 2003, p. 241)

As researchers' and clinicians' cultural competence implies awareness of one's own preconceptions and biases (Quimby, 2006; Smith, 2015), "Well-intentioned researchers and technically skilled clinicians who are uncomfortable with their own issues or uneasy with behaviors associated with sexuality, gender orientation, racism, or lifestyles that differ from their own, may unconsciously communicate value judgments and alienate participants" (Quimby, 2006, p. 865). When formulating overall assessments of mental health problems, there are reasons to believe that clinicians misinterpret problems of minority individuals in making a diagnosis (Snowden, 2003). Cultural competence is the willingness and ability to value the importance of culturing the delivery of services for all segments of the population. It is the development and practice of systems that value differences and are responsive to diversity at all levels of human services (i.e., governance, policy, administrative, workforce, provider, and consumer/client). Clinicians and providers striving to deliver high-quality care to all patients understand that cultural factors influence patients' health beliefs, behaviors, and responses to medical and mental health issues (Galanti, 2000).

Obtaining health information is integral to practicing healthy behaviors and making informed decisions regarding health. Race, culture, and socioeconomic inequities exist in access to health information as well as the health services (Snowden, 2012). Research has shown that the Internet has the potential to decrease the inequity in

obtaining health information by making it accessible to underserved populations (Hunn & Craig, 2009; Snowden, 2012, Warren et al., 2010). It is believed that better overall health status is directly related to greater use of health information resources, and obtaining health information via the Internet is a popular resource. Motivated people can utilize this resource to enhance their capacity to be more active participants in health decisions and prevention. The outcome is a perceived notion that the Internet can be used as a tool for seeking health information (Sosulski & Woodward, 2013; Warren et al., 2010).

Chapter Summary

Throughout the examination of the literature related to the dissertation topic, “the mental health service utilization among African American women,” various research methods and designs were reviewed. According to Creswell (2007), “most qualitative researchers focus on only one approach, for example ethnography or grounded theory, and they try to convince their readers of the value of that approach” (Creswell, 2007, p. 2). However, these researchers utilized different approaches to their qualitative inquiry—narrative, phenomenology, grounded theory, ethnography, and case studies, considering all of them relevant to this topic (Creswell, 2007). Additionally, both quantitative and mixed-methods research was utilized when studying equity and cost of mental health services (Akhavan & Tillgren, 2015; Cheng & Robinson, 2013; Greenberg, Fournier, Sisitsky, Pike, & Kessler, 2015; Snowden, 2012; Sosulski & Woodward, 2013). These researchers found that stigma was also a significant barrier to mental health treatment services, which has an impact on client/patient perceptions of achieving equity in care (Akhavan & Tillgren, 2015; Cheng & Robinson, 2013; Greenberg et al., 2015; Sheridan et al., 2012; Snowden, 2012; Sosulski & Woodward, 2013). Clinical practice relies on

mental health research, primarily investigations driven by their capacity for statistical analysis. However, qualitative data collection and analytical methods are increasingly valued (Copeland & Butler, 2007; Quimby, 2006; Ross et al., 2015).

The evidence of bias in diagnoses underscored a robust phenomenon in African American mental health. For more than two decades, researchers have documented that African Americans have higher than expected rates of diagnosed schizophrenia and lower rates of diagnosed affective disorders. These differences have aroused suspicion that clinicians, indeed, are biased in the course of routine practice. (Snowden, 2003, p. 241)

According to a report published by the NAMI (2015), only about one-quarter of African Americans seek mental health care, compared to 40% of Whites (Campbell & Long, 2014; Sosulski & Woodward, 2013). Historically, African Americans have been, and continue to be, negatively affected by prejudice and discrimination in the health care system (Cheng & Robinson, 2013; Hunn & Craig, 2009; Paradies et al., 2015; Shavers et al., 2012; Smith, 2015; Warren et al., 2010). Misdiagnoses, inadequate treatment, and lack of cultural competence by health professionals breed distrust and prevent many African Americans from seeking or staying in treatment (NAMI, 2015; Ojelade et al., 2011; Smith, 2015; Snowden, 2003, 2012). Socioeconomic factors play a significant role and can cause treatment options to be less available (Greenberg et al., 2015; Snowden 2012). According to the U.S. Census Bureau (2015), as of 2012, 19% of African Americans have no form of health insurance (NAMI, 2015). The Affordable Care Act (Patient Protection and Affordable Care Act, 2010) is making it easier and more affordable to obtain health insurance.

More commonly, lack of quality care may be one of the many aspects, such as access to economic resources and disadvantages in the labor market, that make members of underprivileged groups more vulnerable to adverse consequences of psychiatric disorders and thereby less likely to recover once they become ill (Breslau et al., 2005; Carrington, 2012). This overall point is partly supported by research on depressive episodes, indicating that recovery can be impeded by events that intensify stressful life situations or promoted by events that reverse or resolve those conditions (Breslau et al., 2005).

Service utilization by African American women in community-based mental health programs is low to nonexistent. Research has cited that African Americans with low incomes are more likely to get the most severe labels and be diagnosed with schizophrenia (Logan et al., 2007; McNeil & Kennedy, 1997; Rollock & Gordon, 2000; Snowden, 2012). They are more likely to use outpatient medical facilities than to seek services in a psychiatric facility (Logan et al., 2007; McNeil & Kennedy, 1997; Rollock & Gordon, 2000). What is vital is observing the two tenets of the life-course-perspective approach that incorporates history and culture, not recapping the complications of the past in the mental health area, and embracing culturally sensitive services. (Logan et al., 2007; McNeil & Kennedy, 1997). The overall objective of the mental health system ought to be to assist African Americans in the most culturally sensitive manner possible. Understanding the culture will assist in providing culturally sensitive services (Logan et al., 2007; McNeil & Kennedy, 1997).

Another factor is the lack of African American mental health professionals that are culturally competent (Copeland & Butler, 2007; Hunn & Craig, 2009; Mynatt et al.,

2008; Quan et al., 2008; Smith, 2015). Only 3.7% of the members in the American Medical Association and 1.5% of members in the American Psychological Association are African American (National Institutes of Health, 2015). Smith (2015) posited that,

The mental health profession must actively challenge societal policies or practices that threaten the emotional, social, and psychological well-being of the African American population and all racial and ethnic groups as well as diverse groups created by intersecting cultural identities. (p. 61)

Sosulski & Woodward (2013) determined that more research is needed to clearly determine the factors that impede the help-seeking behaviors of African American women with mental disorders. Their research evidenced that the severity and the kind of mental health disorder plays a significant role in the decision-making process of the person (Snowden, 2012; Sosulski & Woodward, 2013; Warren, 2010). Difficult challenges for mental health systems are implementing and sustaining evidence-based practices and other treatment modalities for African American women (Quimby, 2006). Recent studies indicate that it is difficult to engage ethnic minorities in research, which creates challenges that may be confounded in the context of mental health issues, making it difficult to recruit participants for studies (Waheed et al., 2015).

Historical improprieties experienced by African Americans as participants in medical research are still reflected as negative attitudes toward research and mistrust of scientists in some contemporary African American communities. In particular, the legacy of the U.S. Public Health Syphilis Study at Tuskegee (Pinn, 2011) among African Americans resulted in profound apprehension toward participation in health-related research and skepticism toward the benefits and implications of research. However,

recent evidence is ambiguous about the lasting impact of the study on the willingness of African Americans to engage in medical research. Thus, increased attention has focused on understanding and overcoming barriers to research participation by minority groups (Brown & Topcu, 2003; Pinn, 2011).

These researchers have found that compared to having issues with participants being comfortable with studies, there is a perception and an effect of racial and ethnic discrimination and institutional racism within health care settings (Cheng & Robinson, 2013; Shavers et al., 2012). While disparities in mental health still exist for ethnic/racial communities, some efforts have been implemented in order to solve this problem, however, more work is needed in this area, specifically for African American women (Smith, 2015).

The empowerment process—which includes group involvement by untrained women committed to improving their own situations and in effecting social change through the redistribution of resources—is expected to produce individual and group results that help sustain or advance women's health. In other words, empowerment policies and approaches do not have to focus explicitly on health in order to impact health (Stein, 2000).

Chapter 3: Research Design Methodology

Introduction

While disparities in mental health services still exist within ethnic/racial communities, some efforts have been implemented to solve this problem. However, a review of literature has indicated that more work is needed in this area, specifically for African American women with MDD (American Psychiatric Association, 2013; Smith, 2015). The purpose of this quantitative design research was to analyze factors that may affect African American women with three significant mental health diagnoses, major depressive disorder, bipolar disorder, and schizophrenia, who were receiving mental health support services at various ages, compared to White and Latino women. The primary objective of this quantitative study was to examine the characteristics of formerly homeless African American women with mental illness who reside in a mental health supportive housing program operated by a not for profit organization located in an urban setting in New York City, New York.

Creswell (2014) stated that quantitative research not only assists in substantiating the problem, but there may also be hypotheses and questions that may need to be addressed. In this case, an analysis of the data may answer questions related to the factors that affect the help-seeking behaviors and utilization of mental health support services by single, formerly homeless African American women. By studying a sample of African American woman diagnosed with schizophrenia, major depression, and bipolar depression, statistical archived data research will provide a quantitative

description of selected variables (Creswell, 2014). A researcher using quantitative methods tests a theory by specifying narrow hypotheses and collecting data to support or refute the hypotheses (Creswell, 2014). The theoretical lens through which this candidate viewed the variables in this research was based on critical race theory and the theory of access (Penchansky & Thomas, 1981) through Andersen's (1995) behavioral model of health services utilization.

Critical race theory has been applied to numerous subjects such as the analysis of conflict between integration ideals and clients' interests in school desegregation litigations, incremental methods to attaining racial equality, supposed neutral principles of constitutional law legitimization of discrimination through anti-discrimination (i.e. color-blind) law, racially based jury nullification and race-conscious districting (Brown, 2003; Crenshaw et al., 1995; Delgado & Stefancic, 2000). Because critical race theory accentuates what racial stratification means and how it operates, this theoretical tradition can contribute to the sociology of mental health by relating emotional problems formed by racial stratification, problems that often surpass standard conceptions of mental health (Brown, 2003). Integrating a critical race perspective would draw attention to the point that mental health and mental health problems are often hypothesized to be a function of internal, individual level etiologic factors (Brown, 2003).

The Andersen (1995) model, also known as the behavioral model of health services is the most common framework used to understand individuals' access to health care. This socio-behavioral model has been persuasive in explaining individual's use of health care services, especially physician care (Derose, Gresenz, & Ringel, 2011). The framework considers an individual's use of health services to be a role of three types of

factors, such as demographics, health beliefs, and other individual characteristics (Derose et al., 2011). Demographics and diagnosis are variables that were analyzed in the research study.

The disparities related to health care access for minority populations in the United States is well documented, however researchers have few strategies to effectively address them (Derose et al., 2011). In order to effectively develop policies and impact program development that decrease disparities in health care access and utilization, a comprehensive understanding of the multiple factors that stimulate them is needed (Derose et al., 2011). This research will provide robust evidence to inform additional policies for improving access to mental health services and decreasing disparities.

Research Questions

The research questions for this dissertation study were directly related to single, formerly homeless African American women with a diagnosis of schizophrenia, major depression, and bipolar depression who received mental health support services. This quantitative study was descriptive in nature, designed to examine the relationship between the age, diagnosis, and race of the African American woman as compared to White women and Latin American women, who received mental health support services in an affordable-housing setting.

The research questions that guided this dissertation study are as follows;

1. Is there a significant difference in the mean age by gender of the individuals receiving mental health supportive services?

- a. Null Hypothesis (HO1 - a): There is no significant difference in the mean age by gender of the individuals receiving mental health supportive services.
 - b. Alternative Hypothesis (AH1 - b): There is a significant difference in the mean age by gender of individuals receiving mental health supportive services.
2. Is there a significant difference in the mean age of the women receiving mental health supportive services by race?
- a. Null Hypothesis (HO2 - a): There is no significant difference in the mean age of women receiving mental health supportive services by race; in African American women versus Latin American women versus White women.
 - b. Alternate Hypothesis (AH2 - b): There is a significant difference in the mean age of women receiving mental health supportive services by race; in African American women, versus Latin American women versus White women.
3. Is there a significant difference in diagnosis by race of women receiving mental health supportive services?
- a. Null Hypothesis (HO3 - a): There is no significant difference in the diagnosis of a specific mental illness in African American women versus Latin American women versus White women receiving mental health supportive services.

- b. Alternate Hypothesis (AH3 - b): There is a significant difference in the diagnosis of a specific mental illness in African American women versus Latin American women versus White women receiving mental health supportive services.

Research Context

This research study was conducted utilizing archival data. According to the Common Rule, 45 CFR 46, Subpart A-Protection of Human Subjects, this research posed no *human risk* and there was no identifiable information of any mental health consumers in this study sample. This study explored the relationship between the African American women and their diagnoses and other women. The study examined gender, age, race, and diagnosis.

Research Participants

The participants identified for this research study were single adult individuals, 21 - 61 years of age, who resided in a non-profit operated housing facility in an urban setting of New York that provided mental health support services. This housing facility is a community based housing facility that offers mixed use housing for low-income single adults, as well as the target population for this study. The significance of mixed use, community based housing is ideal for reducing the stigma of living in a facility specifically for a vulnerable population. This model of supportive housing has proven effective in New York State (Center for Urban Community Services, 2012).

Instruments Used in Data Collection

Case records are maintained by qualified mental health professionals (social workers, case managers, and clinicians), and they are used to manage and objectively

document fact-based information for the population served. The case record is maintained in a manner with the understanding that records may be reviewed and used by other professionals, including county attorneys, service providers (therapists, doctors, psychologists), and other professionals. Most community-based special-needs housing facilities use a secure, web-based integrated case management system to document the services that are provided to all consumers. In this case, this web-based case-management system maintained and archived the demographic data that were used for this study. The documentation is preserved and can only be accessed by authorized log-in by designated users. Once logged into the system, various menus can be accessed to create specific reports and extract data for multiple uses.

Additionally, the database allows the user to choose specific time frames and specific variables to create spreadsheets that contain clearly sorted reports in numerical and text formats, while ensuring the confidentiality of the participants. The participants are documented by an identification number that contained no other classifying information other than gender, age, race, and diagnosis. The data analyzed was for a 2-year period, January 1, 2015 through December 31, 2016, with a total of 323 cases. Once the data were exported into a Microsoft Excel spreadsheet, it was uploaded, filtered, and prepared for the Statistical Package for the Social Sciences (SPSS) analysis, which produced the statistical spreadsheets and charts to answer the aforementioned research questions. All of this statistical data analysis is explained in Chapter 4.

Procedures for Data Collection and Analysis

Quantitative procedures used to interpret the data in the form of a descriptive analysis focused on the means and standard deviation for all the dependent and

interdependent variables (Creswell, 2014). The use of SPSS afforded this researcher the ability to organize, quantify, manipulate, and evaluate the achieved data in order to answer and respond to the questions that guided this research. The computed data results are illustrated in the form of tables and graphs that display the relationships of the scores to the dependent variables identified from this dissertation study (Huck, 2012).

Cross tabulation and chi-square tests were performed to see whether or not there was a significant relationship between the African American women, the White women, and the Latin American women by their age, race, and diagnosis. Finally, the analysis of all the data in SPSS were used to determine whether or not a relationship existed between the variables. The output produced by SPSS is labeled and represented in the form of tables to display the outcomes in Chapter 4.

Summary

A more comprehensive understanding of the mental health support service utilization and the factors that affect African American women with mental health issues will provide a platform for advocacy, for equitable access to quality services, and resources by insisting on institutional and societal change (Smith, 2015). The fair distribution of resources and rights for all members of society relates to social justice, and the key component is equity—equal access to goods and services for everyone.

Multicultural practices are intertwined with advocacy and social justice (Smith, 2015; Snowden, 2012). The main focus of the data analysis for this research was based upon descriptive statistics used to summarize the reports and provide a clear picture of the barriers/factors experienced by African American women, the disparities in access to

mental health care, and what can be done to improve aspects of mental health support services from a social justice perspective, and these are discussed further in Chapter 5.

Chapter 4: Results

Although there is increasing research focused on African Americans with mental illness, few researchers have addressed the factors that affect African American women with mental illness, especially those that were formerly homeless. Research has focused on examining the personal traits of homeless people to identify possible explanations for their homelessness, however, it has included limited data related to mental illness (Tompsett et al., 2006). The objective of this quantitative study is to examine the characteristics of formerly homeless African American women with mental illness who reside in a mental health supportive housing program operated by a not for profit organization located in an urban setting in New York City, New York.

Along with homelessness, we must address the issue of those who are diagnosed with mental illness. Being homeless can put people at risk for poor physical and mental health. According to the Coalition for the Homeless (2015), many of New York City's single homeless adults have higher rates of serious mental illness, addiction disorders, and other severe health problems. The intent of this study was to analyze the factors that affect formerly homeless African American women with mental illness that reside in a mental health supportive housing program located in an urban setting in New York City. The examination of archival data was used to assess this population's characteristics.

As identified in the review of literature, previous studies have determined that the age of African American females is significant in the diagnosis rendered by the psychiatrists. Research shows that some mental illnesses tend to manifest itself later in life in groups with higher mean age, while other groups are diagnosed with certain mental illness at a younger age. These incidences are determined to be related to a lack of knowledge, cultural sensitivity, and awareness of the African American population.

Research Questions

The research questions that guided this dissertation study were designed to analyze factors that may affect African American women with mental illness that receive supportive mental health services in a housing program of a not for profit organization;

1. Is there a significant difference in the mean age by gender of the individuals receiving mental health supportive services?
 - a. Null Hypothesis (HO1 - a): There is no significant difference in the mean age by gender of the individuals receiving mental health supportive services.
 - b. Alternative Hypothesis (AH1 - b): There is a significant difference in the mean age by gender of individuals receiving mental health supportive services.
2. Is there a significant difference in the mean age of the women receiving mental health supportive services by race?

- a. Null Hypothesis (HO2 - a): There is no significant difference in the mean age of women receiving mental health supportive services by race; in African American women versus Latin American women versus White women.
 - b. Alternate Hypothesis (AH2 - b): There is a significant difference in the mean age of women receiving mental health supportive services by race; in African American women, versus Latin American women versus White women.
3. Is there a significant difference in diagnosis by race of women receiving mental health supportive services?
- a. Null Hypothesis (HO3 - a): There is no significant difference in the diagnosis of a significant mental illness in African American women versus Latin American women versus White women receiving mental health supportive services.
 - b. Alternate Hypothesis (AH3 - b): There is a significant difference in the diagnosis of a significant mental illness in African American women versus Latin American women versus White women receiving mental health supportive services.

Data Analysis and Findings

Findings and analysis are discussed by research question.

Research question 1. Research question 1 asked, Is there a significant difference in the mean age by gender of the individuals receiving mental health supportive services?

Figure 4.1 illustrates the descriptive statistics of the mean age of the single formerly homeless adults who were the subjects of this research study. The bar chart depicts the entire population ($N=323$) studied for this research. Table 4.1 provides results by gender. An independent t -test was conducted to compare the mean age (dependent variable) to female ($M = 53.3$, $SD = 9.9$) and male ($M = 52.9$, $S.D. = 10.1$), $t(321) = .364$, $p = .716$. Since $p > .05$ which is the alpha used in this study ($\mu_1 = \mu_2$), the null hypothesis was accepted. There was no significant difference in mean ages for the females and males as represented in the graphic below. The alternative hypothesis is rejected.

The subsequent tests were conducted after splitting the data and only testing the female participants, since that is the focus of this research. By doing so, the number of participants was $N = 145$. This represents African American women, Latin American women, White women, and other women that failed to identify in a particular category of race or the sample was not large enough to include (i.e. Asian American women).

Table 4.1

Independent t -test Results: Age by Gender

| | | Group Statistics | | | |
|-----|--------|------------------|-------|----------------|-----------------|
| | GENDER | N | Mean | Std. Deviation | Std. Error Mean |
| AGE | Female | 145 | 53.30 | 9.948 | .826 |
| | Male | 178 | 52.89 | 10.108 | .758 |

Note. N = Sample; M = Mean; $S.D.$ = Standard Deviation; SEM = Standard Error Mean

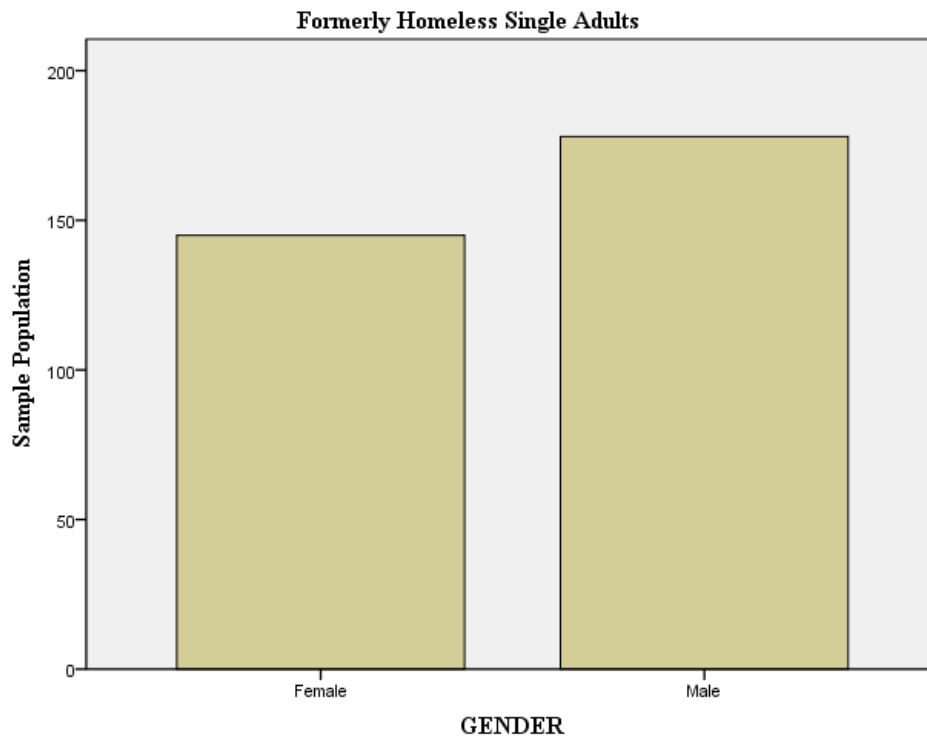


Figure 4.1 Descriptive: Frequency for Gender.

Research question 2. Research question 2 asked this, Is there a significant difference in the mean age of women receiving mental health supportive services by race? In order to assess the mean age of the females that reside in this mental health supportive housing program a univariate ANOVA test was conducted to determine if there was a significant difference in their ages by race. A one-way ANOVA test between subjects was conducted to compare the effect of race on mean age of the female participants.

Table 4.2 depicts the univariate analysis of the dependent variable of age as it relates to females. This test revealed [$F(0, 3) = 5.29, p = .002$] that there is a significant difference in the mean age of African American women ($M = 53, n = 81$) versus ($M = 59, n = 31$) White women, but not Latin American women ($M = 50, n =$

30). Therefore, the null hypothesis is rejected and the alternate hypothesis is accepted. Based upon research one would ascertain that the based on the following tables (Table 4.2 and Table 4.3) White women who utilize the mental health supportive services are older, but far fewer than the African American women within the mental health supportive housing program chosen for this study in this geographic area. This research indicated that African American women find themselves homeless and in need of services at a higher rate than their White counterparts. This also supports previous research studies of this population.

Table 4.2

Descriptive Statistics: Mean Age by Race

| GENDER | RACE | Mean | Std. Deviation | N |
|--------|------------------|-------|----------------|-----|
| Female | African American | 52.72 | 9.231 | 81 |
| | Latin American | 49.87 | 12.062 | 30 |
| | Other | 46.67 | 6.028 | 3 |
| | White | 58.77 | 7.526 | 31 |
| | Total | 53.30 | 9.948 | 145 |

In order to determine which groups had significant differences in the means, a Tukey post hoc test was conducted. Table 4.3 provides comparisons on age and race. The results revealed that there is significant difference ($p = .017$) in the mean age between African American and White women and Latin American women.

Table 4.3

Descriptive Statistics: Multiple Comparison of Age & Race

Tukey HSD

| (I) RACE | (J) RACE | Mean Difference (I-J) | Std. Error | Sig. | 95% Confidence Interval | |
|-----------------------------|-----------------------------|-----------------------------|---------------|-------------|----------------------------|----------------|
| | | | | | Lower Bound | Upper Bound |
| African American | Latin American | 2.85 | 2.050 | .508 | -2.49 | 8.18 |
| | Other | 6.05 | 5.640 | .707 | -8.63 | 20.73 |
| | White | -6.06* | 2.026 | .017 | -11.33 | -.79 |
| Latin American | African American | -2.85 | 2.050 | .508 | -8.18 | 2.49 |
| | Other | 3.20 | 5.809 | .946 | -11.92 | 18.32 |
| | White | -8.91* | 2.457 | .002 | -15.30 | -2.51 |
| Other | African American | -6.05 | 5.640 | .707 | -20.73 | 8.63 |
| | Latin American | -3.20 | 5.809 | .946 | -18.32 | 11.92 |
| | White | -12.11 | 5.800 | .163 | -27.20 | 2.99 |
| | African American | 6.06* | 2.026 | .017 | .79 | 11.33 |
| White | Latin American | 8.91* | 2.457 | .002 | 2.51 | 15.30 |
| | Other | 12.11 | 5.800 | .163 | -2.99 | 27.20 |

Note. Based on observed means. The error term is Mean Square(Error) = 92.027.^a

*. The mean difference is significant at the .05 level.

a. GENDER = Female

Research question 3. Research question 3 asked, Is there a significant difference in race by diagnosis of the female participants receiving mental health supportive services? The chi-square test conducted represents 145 of the female participants that have one of the three mental health diagnoses covered in the study.

A chi-square test of independence was performed to examine the relation between race and diagnosis of the female population of this mental health supportive housing program, $\chi^2(2, N = 145) = 3.38, p = .020$.

Based on previous research studies and the study conducted by this researcher it has been determined that African American women are more likely to be diagnosed with schizophrenia at a younger age than both White women and Latin American women. This supports the need for more culturally sensitive psychiatrists and other mental health service providers that often misdiagnose African American women because they are unfamiliar with the characteristics and traits that are specific to this population. The expected count is much lower than the actual number of African American women diagnosed with schizophrenia. The expected number of White women diagnosed with schizophrenia is higher than the actual.

Table 4.4 indicates race by diagnosis. Table 4.4 illustrates that there is a significant difference based on the p value/significant value which is less than .05 [$p > .003$], indicating that the null hypothesis is rejected ($\mu_1 \neq \mu_2$). There is an alternate hypothesis to state and it is true.

Table 4.5 provides details on a Pearson chi-square analysis of race by diagnosis. The Pearson chi-square analysis was another test that supported the significant differences in the relationship between race and diagnosis. Thus the alternative hypothesis is accepted.

Table 4.4

Chi-Square: Female - Race by Diagnosis

| | | Diagnoses - Axis I Text | | | | |
|-----------------------|----------------------------------|-------------------------|---------------------|--------|---------------|--------|
| | | Major | | | | |
| | | Bipolar Disorder | Depressive Disorder | Other | Schizophrenia | Total |
| RACE African American | Count | 13 | 21 | 10 | 37 | 81 |
| | Expected Count | 14.5 | 29.6 | 7.3 | 29.6 | 81.0 |
| | % within RACE | 16.0% | 25.9% | 12.3% | 45.7% | 100.0% |
| | % within Diagnoses - Axis I Text | 50.0% | 39.6% | 76.9% | 69.8% | 55.9% |
| Latin American | Count | 10 | 11 | 3 | 6 | 30 |
| | Expected Count | 5.4 | 11.0 | 2.7 | 11.0 | 30.0 |
| | % within RACE | 33.3% | 36.7% | 10.0% | 20.0% | 100.0% |
| | % within Diagnoses - Axis I Text | 38.5% | 20.8% | 23.1% | 11.3% | 20.7% |
| Other | Count | 0 | 1 | 0 | 2 | 3 |
| | Expected Count | .5 | 1.1 | .3 | 1.1 | 3.0 |
| | % within RACE | 0.0% | 33.3% | 0.0% | 66.7% | 100.0% |
| | % within Diagnoses - Axis I Text | 0.0% | 1.9% | 0.0% | 3.8% | 2.1% |
| White | Count | 3 | 20 | 0 | 8 | 31 |
| | Expected Count | 5.6 | 11.3 | 2.8 | 11.3 | 31.0 |
| | % within RACE | 9.7% | 64.5% | 0.0% | 25.8% | 100.0% |
| | % within Diagnoses - Axis I Text | 11.5% | 37.7% | 0.0% | 15.1% | 21.4% |
| Total | Count | 26 | 53 | 13 | 53 | 145 |
| | Expected Count | 26.0 | 53.0 | 13.0 | 53.0 | 145.0 |
| | % within RACE | 17.9% | 36.6% | 9.0% | 36.6% | 100.0% |
| | % within Diagnoses - Axis I Text | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

Table 4.5

Pearson Chi-Square: Female – Race by Diagnosis

Chi-square Tests

| | Value | df | Asymptotic Significance (2-sided) |
|--------------------|---------------------|----|--------------------------------------|
| Pearson Chi-Square | 24.922 ^b | 9 | .003 |
| Likelihood Ratio | 27.151 | 9 | .001 |
| N of Valid Cases | 145 | | |

Note. b. 6 cells (37.5%) have expected count less than 5. The minimum expected count is .27.

Summary of Results

In summary, Chapter 4 presented the results of the statistical tests conducted on the archival data retrieved from a secure web-based electronic health record storage system of a New York City not-for-profit organization that provides housing and supportive services for single mentally ill adults. The quantitative study revealed that there are significant differences in African American, Latin American, and White women who seek mental health supportive services. The results of the analysis also revealed that there are no significant difference in mean age and gender of the entire population ($N = 323$). However, there were exceptions related to the race of these women as it pertained to their age and diagnosis. A more in-depth explanation of the research findings and implications will be included and discussed in Chapter 5.

Chapter 5: Discussion

Introduction

Chapter 5 includes a discussion of the implications of research findings reported in Chapter 4, while also discussing the limitations of this research. This chapter offers recommendations and insight for policy makers, community based organizations, service providers, and other professionals within the mental health and supportive housing industry. This dissertation researched and analyzed some of the factors that affect African American women with mental illness.

The decision to examine African American women who reside within supportive housing programs in an urban setting in New York City, was based on the need to analyze the help-seeking behaviors of this population in an effort to bring attention to disregarded issues. These issues include, but are not limited to, the disregard for any intervention or preventative measures that affect this population, that eventually leads to homelessness. The inability to relax, being disconnected from her own personal needs, feeling unworthy, overworking, and being disconnected from others, are all symptoms of depression. This collection of depressive symptoms, as stated in earlier chapters, is called the Sisterella complex (Logan et al., 2007).

Research finds that these symptoms begin to manifest themselves after age 35, thus resulting in the mean age of women in these mental health supportive housing programs is 53 years of age. By the time these women have suffered a series

of episodes of depressive incidents, hospitalizations, and personal losses, they find themselves in homeless shelters, eventually being referred to specialized supportive housing programs. The sample population for this case study was 145 single, formerly homeless women, aged 21 – 81 years, residing within six different mental health supportive housing programs operated by a not for profit organization in Bronx County, New York.

Once approval was granted by the organization, the archival data was extracted from a secure web-based data bank that stores the records of these participants. A report format was constructed for the purpose of this study, without including any identifying markers of the participants in order to protect their confidentiality. An assessment of archival data was done to highlight the traits and characteristics of African American women with a diagnosed mental illness. A series of quantitative tests were performed to determine whether or not there was a relationship between the age, race, and, diagnosis of the female participants.

The review of literature revealed a lack of participation in research studies by this population. This results in the African American community not being sufficiently represented in the allocation of resources, or the effective application of services, along with a lack of cultural sensitivity to their needs and a lack of diversity in those who assist in meeting their needs. The literature also revealed that there were numerous studies initiated, but far too many were inconclusive due to mistrust, external environmental factors, and crimes against this population. The methodological approach of previous research studies conducted were mixed

methods, quantitative, and qualitative, all in an effort to identify and eliminate the barriers/factors that affect the help-seeking behaviors African American women.

Implications of Findings

This dissertation research offers awareness that housing impacts the health and well-being of individuals with mental illness. This basic need is overlooked. Once people are placed in permanent housing from homeless shelters, their lives are usually enhanced and the risk factors related to health and mental health are often minimized. A study conducted by a research team revealed that supportive housing programs provides stability for at-risk individuals and the models vary based upon the population served (McGinnis, Polvere, Smith, & Dewar, 2017). The results of the quantitative tests that were conducted provided insight into the characteristics of this population and the need for more specialized services specifically for African American women.

The entire population consisted of 323 single, formerly homeless individuals (females – 145 and males – 178). The independent *t*-test determined that the average/mean age of participants in the program is 53 years old and the comorbidities rate of this population is high. This is an important characteristic, because it supports research studies that acknowledges the fact that individuals with mental health issues live longer in stable housing environments with supportive services; that with keeping appointments, medication management, financial management, and community involvement, all of these contribute to health and wellness.

The number of female participants was 145, which represents African American women, Latin American women, White women, and other women that failed to identify in a particular category of race or the sample was not large enough to include (i.e. Asian American women). In order to assess the mean age of the females that reside in this mental health supportive housing program a univariate ANOVA test was conducted to determine if there was a significant difference in the women's age by race. This test revealed that there is a significant difference in the mean age of African American women ($M = 53$) and the mean age of White women ($M = 59$), but not the mean age of Latin American women ($M = 50$). This number supports research that indicates that a greater number African American women find themselves homeless and in need of services, as compared to their White counterparts. More accessibility, affordability, availability, acceptability, and accommodations to mental health services is provided to White women.

When conducting a chi-square test, one is looking for a relationship between two variables. The inferential statistical test allowed this researcher to conduct a cross tabulation test using the mental health diagnosis of the three mental health disorders selected for this study, major depressive disorder, bipolar disorder, and schizophrenia among the 145 female participants ($n = 145$). The relationship between these variables was significant, thus the null hypothesis is rejected and the alternate hypothesis is accepted. Based upon the tests conducted it is evident that there is a significant difference ($p\text{-value} = 0.05$) in the mean age of the female participants as it relates to their diagnosis. The chi-square test conducted represents 145 of the female participants that have one of the three mental health diagnoses covered in the study.

Previous research studies and the study conducted by this researcher, determined that African American women are more likely to be diagnosed with schizophrenia at a younger age than both White women and Latin American women, thus, supporting the need for more culturally sensitive psychiatrists and other mental health service providers. This also supports previous research that African American women are misdiagnosed because the psychiatrists and/or other mental health professionals are unfamiliar with the characteristics and traits that are specific to this population.

Insights and implications for the policy makers, community based organizations, advocates, and supportive housing mental health service providers are discussed in this research study. For policy makers, implications impacting policy must be conscious of race, class, and gender when enacting laws so as not to exclude or overlook culturally sensitive matters related to this populations. Policy makers need to allocate more funds based in communities for specific populations.

Concerning community based organizations, these research findings support the following implications that assist this population in obtaining supportive mental health services. The objectives for community based organizations should reflect more accurately the population at need. When establishing internal policies and procedures, the target population should be foremost in their minds. When establishing services, preventive measures should be among the policies that are implemented. For example, goals and objectives need to more accurately reflect the realities of the population.

Service providers should be required to attend more comprehensive and regular trainings that cover areas of race, gender, and culture, especially as it relates to the

targeted population that is highlighted by this research. Additionally, evaluations of service providers and programs should be based upon improvements in these areas.

The hiring of staff and administrators must include seeking those who are well versed in the needs of the population they serve. Those hired must be culturally sensitive and supportive, especially as it relates to the supportive housing environment. Supportive housing needs to continue to be located within the community, so as not to isolate and stigmatize this population. It is important for these consumers to remain connected to families and other supports.

The issue of culturally competent mental health providers is a more global issue, because they include staff and administrators in hospitals and clinics throughout the country. All hospitals and clinics must incorporate culturally sensitive practices into their everyday interactions with this population. This would minimize the underdiagnoses or misdiagnoses of African American women when they come in for treatment, be it medical or psychiatric. The above implications for the areas that are described would go a long way in the support of equalizing and lessening the costs that are associated with the misdiagnosis and underdiagnoses of this population.

The client – counselor (mental health service provider) relationship is a crucial role in the success of effectively addressing mental health and other issues. An important aspect to the success of the relationship on both a personal and professional context is to have a good fit. The service providers may be experts in their field of study, they may have numerous years of experience, be credentialed, licensed, highly skilled, and however the mere existence of a social connection, can be the key to a successful

working relationship. As in any situation, there are certain people with whom you mesh well in terms of getting along and others with whom you do not have a good relationship. The client is more likely to stay connected to services and work toward mutually agreed upon goals when they are able to communicate with their service provider and develop a good working relationship. One of the primary indicators of a clients' progress in their mental health treatment is the quality of the relationship that exists between the client and the mental health service provider.

Personal fit refers to the aspects of the relationship between the client and the mental health provider where they like, respect, and are able to work collaboratively with each other. When working toward a goal, if the atmosphere between client and provide is relaxed, if mutual likeability and respect exist, then the chances for success are high. Most service providers make diligent efforts to develop mutual likeability and respect with all their clients. Sometimes, in spite of these efforts, the mutual likeability and respect is nonexistent.

There are many factors which affect whether we like a person which can be outside of that person's control. Research has found that race, culture, socioeconomic status, age, and other personal characteristics (the counselor may remind them of someone from their past) are common factors that affect the client counselor relationship between different races. At other times these challenges exist within the same race. It is important for both the client and the mental health service provider to determine whether the goodness-of-fit is present between them and to make other provisions if it is not. This can include working toward attempts to achieve a good fit or providing the client with a referral to other services where there may be a better opportunity of having a

good fit. A good leader recognizes and understands that the ultimate goal is to achieve results, despite who provides the service.

Limitations

The findings of this dissertation study demonstrate that additional information is needed in order to address the factors related to African American women's help-seeking behaviors. One limitation is sample size. A study of a larger population is warranted to expand this research and its findings. Gauging the sensitivity and training experience of researchers would support a more in-depth study.

Additionally, the refusal rates of the African American and the Latin American population may be lessened if the interviewers were able to spend more time developing trust. Fears and suspicions concerning their financial and/or immigrant status may also be factors that can be helped by interviewers who can also provide assistance in these areas.

Previous researchers have used various forms of qualitative and/or mixed methods in order to obtain similar data, however it was solicited over an extensive period of time over a broader geographic area. The evidence provided in this study indicates that mental health supportive housing is beneficial, but further research is needed to clarify the model and determine what aspects are most effective. Research shows that individuals that are housed have better outcomes, that those that are homeless. Connections with family and other social relationships and activities provide confidence and security.

Another limitation of this dissertation study is the lack of direct questionnaires, surveys, and case studies. Several survey instruments were

developed by researchers as a method of obtaining self-reported mental health information from patients, in an effort to provide more comprehensive services. For example, the Patient Health Questionnaire (PHQ-9) is a nine-question survey that was proposed as a means of gathering information for this research study (Kroenke, Spitzer, & Williams, 2001). It was discovered that health care physicians are distributing it to their patients to ascertain information related to depression and depressive symptoms. Since depression was the most common mental illness and is associated with severe impairment in physical, social and role functioning, and with higher health care utilization, the PHQ-9 is a useful instrument (Kroenke et al., 2001).

Based upon the above limitations, this researcher chose archival data to look at characteristics that exist in this population. Additionally, after working with this population, it became apparent that this quantitative study would garner more information about characteristics.

Recommendations

In January of 2016, Governor Andrew Cuomo announced an ambitious 5-year plan for supportive housing and to address homelessness, allocating \$1.97 billion dollars to these programs and initiatives (McGinnis et al., 2017). This appears to be vital to the continuation of the development of additional supportive housing units, however, who will have access to these services? If the African American community continues to be provided opportunities to these housing services based upon the benefits that are gained, the average age of those receiving services can increase. If these service dollars can also be allocated to enhance the cultural

competency of service providers, the diagnosis and treatment of African American women will improve. In order to meet the needs of this population, there needs to be educational forums that support leadership development for providers. As a form of building human capital, it would be helpful to have an integrated and a disciplined plan, one where all of the parts fit and where accountabilities are clear (Hall, 2008).

Mental health service providers are driven by evidence based practices and person centered approaches, however the regulatory bodies that govern the programs stipulate the types of services offered and to whom. It is difficult to engage African American women in mental health treatment services when they are older and have longer episodes of homelessness (Sosulski & Woodward, 2013). Oftentimes these women have more than one mental health diagnosis and as well as medical issues. Therefore, the appropriate services should be assessed and offered at a younger age. The cost of providing mental health and medical services guides the delivery. The five “A’s” affordability, availability, accessibility, accommodations, and acceptability, are all designed to determine how the providers’ charges relate to the client’s ability and willingness to pay for services (Andersen, 1995; Penchansky & Thomas, 1981).

The literature states that providing culturally sensitive care promotes positive health outcomes to patients, however there is not enough cultural competency training provided to service providers (Crandall, George, Marioni, & Davis, 2003). Medical educators and accreditation groups are gradually recognizing cultural competency as critical to the professional development of physicians (Crandall et al., 2003). Medical professionals must learn to recognize and appropriately address

people of diverse cultures and beliefs and be able to respond to various symptoms, in order to offer the proper diagnosis and treatments. Misdiagnosis and under treatment is a form of discrimination and contributes to stress for this vulnerable population.

A growing number of researchers attribute the existence of health disparities between African Americans and White Americans in the US to social stressors, most prominently the experience of racial discrimination (Soto, Dawson-Andoh, & BeLue, 2011). Despite the increased attention that discrimination has gathered as a risk factor for health and psychological consequences over the past decade, the full extent of the effect of racial discrimination on specific mental health disorders is still not well understood (Soto et al., 2011). Researchers propose that among African Americans, the experience of racial discrimination may be most related to psychiatric disorders with symptom profiles that closely resemble common responses to discrimination (Soto et al., 2011). This supports the need for more culturally competent mental health service providers.

The proposed changes to health care, the Affordable Care Act (Patient Protection and Affordable Care Act, 2010), Medicare and Medicaid, along with the way mental health services are rendered, places us at risk of drastic cuts, limitations, and restrictions at the hands of managed care organizations and other actions by political leaders (McGinnis et al., 2017). These changes will create an environment where clients who were once able to freely access mental health services, will be faced with other factors that may further discourage service utilization. This researcher recommends using the data from this study to support legislation that would preserve health care specifically for this population.

Further research in the area of the effectiveness of the services and how to engage more African American women is required. During a time when the African American community is experiencing increased crime (i.e. domestic violence, police shootings, victims of police shootings, victims of random violence, racial tensions, discrimination, financial crisis, lack of education, etc.) the levels of depression have and will increase. How and who will reach out to the females in the African American community to provide assistance? How will services be provided and will African American females seek the help needed? It is recommended that involving the African American female in the assessment and development of services be a priority.

There is a need for community leaders to bring awareness to the African American community, specifically African American women. This can be done by educating the community leaders that are in places of worship, community centers and other places that provide support for this population. African American women must be able to obtain services in a non-judgmental, safe, environment from providers that are sensitive, culturally competent, and willing to accommodate them in non-traditional manners.

Conclusion

The purpose of this study was to analyze the factors that affect formerly homeless African American women as compared to White and Latino women with mental illness who receive mental health supportive services in a non-profit housing facility in New York City. This quantitative study of archival data (January 2015 – December 2016) was initially focused on analyzing the age, race, gender, diagnosis,

level of education and length of stay of this target population in this mental health supportive services housing program. Seeking to gain a more comprehensive understanding of the mental health service utilization of African American women would set the stage for advocacy in the areas of equitable access to quality services and equal distribution of resources by insisting on institutional and societal change within the mental health industry (Smith, 2015). Furthermore, it is the intent of this study to bring into focus the importance of incorporating cultural theories into interpretive stances that can contribute to the mental health industry.

The connection of history, defining mental illness, examining the characteristics that African American women exhibit regarding their distrust of the mental health practitioners and other service professionals, all provided a platform for this research. The significant role that race, culture, socioeconomics, religion, and stigma had on both the practitioner and the consumer offered a clear insight into the challenges that affect African American women seeking mental health services. Mental health, physical health, education, and socioeconomic status are linked, however it is unclear whether racial disparities can be explained (Nicolaidis, et. al., 2010). The stigma of mental illness remains a particularly relevant factor, as does numerous other barriers that influence the treatment of mental health issues (Sickel et al., 2014).

An examination of these characteristics bring value to the patients' experience when utilizing CRT and the behavioral health model. These theories underpinned the characteristics of this population when examining and analyzing the data collected by this researcher.

This researcher hopes that further study of African Americans and their help-seeking behaviors will facilitate mental health treatment-seeking behaviors among this population. This dissertation contributes to the body of research related to this population and mental health. The findings demonstrate that there is valuable data available for stakeholders to gain awareness and devote time to enhancing the skills of service providers that serve the African American community. This quantitative study analyzed the factors of 323 people to determine the effect of obtaining services. Of that total sample, 145 women are in this mental health supportive housing program in an urban setting in New York City, New York. After gathering and sorting the data, independent *t*-tests, chi-square tests, and one-way ANOVA tests determined whether there were relationships and/or if differences existed between genders, age, race, and diagnosis. The study revealed that there was no relationship between age and race. However, there was a significant difference in race and diagnosis, and age and diagnosis. The mean age of 145 African American women and 178 African American men is 53 years of age.

This dissertation discussed the limitations of the study and offered recommendations for further research. This study is not generalizable to all mental health supportive housing programs and the entire African American community, however it does offer valuable awareness to the need for future research. The dissertation study reveals that the significant difference that exists between the diagnosis of African American women and White women is in itself a need for more equitable mental health services. With all of the progress in some areas, there is a significant need for change and equity in others.

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