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African American Women's Perspectives on Mental Health

Kristine Smalls

Philadelphia College of Osteopathic Medicine

School of Professional and Applied Psychology

Department of Clinical Psychology

AFRICAN AMERICAN WOMEN'S PERSPECTIVES ON MENTAL HEALTH

By Kristine Smalls, M.A., M.S.

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DISSERTATION APPROVAL

This is to certify that the thesis presented to us by Kristine Smalls on the 16th day of December, 2022, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

COMMITTEE MEMBERS' SIGNATURES

Beverly White, Psy.D, Chairperson

Stephanie Felgoise, Ph.D., ABPP

Tamika Thomas, Psy.D

Stephanie Felgoise, Ph.D., ABPP, Chair, Department of Clinical Psychology

Robert A. DiTomasso, Ph.D., ABPP, Dean, School of Professional & Applied Psychology

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Abstract

African American women endure multiple stressors from such forms of social oppression as racism and sexism that impact their lives in many ways. Despite those stressors, several barriers impede African American women from seeking the professional mental health they need to cope. Instead, they rely on cultural and historical methods for managing stress, such as religious beliefs and the support of the church community, or they create their own. In this study, 25 women were interviewed to explore the barriers interfering with African American women seeking professional mental health treatment. This study specifically identified and examined three potential barriers: the cultural and historical attitudes toward America's predominant health care institutions, the cultural and historical reliance on religion and the church community for support, and the deficiencies of mental health services available to African American communities. The study identified four themes: Perception of mental health and mental illness; Perception of seeking and providing help; Perception that mental health is unimportant; and Perception of violence by law enforcement and whites. The findings emphasized the importance of considering how African American women develop perceptions of mental health and illness, and how these play a role in their help-seeking behaviors. This study's information will hopefully guide approaches to therapy for African American women.

CHAPTER 1: INTRODUCTION

Statement of the Problem

According to Morris (2016), growing up as an African American girl can lead to a struggle to survive in society due to the expectations placed on them. Whether or not African American girls are regarded in the same way and held to the same standards as their white counterparts impacts their self-identity and social personae, as well as their coping strategies when emotionally and psychologically distressed by living in economically and socially isolated spaces (Morris, 2016). In general, African American girls are held to rigid standards from early adolescence to adulthood, such as spending much of their time in controlled environments (church, school, or family), identifying as heterosexual, avoiding sexual promiscuity, and becoming women who are committed to their families (Morris, 2016). African American females experience a unique form of oppression, strictly held to those standards yet suffering greater societal disadvantages (Perry et al., 2013). For example, African American women were viewed negatively, even as inferior, based on the color of their skin (Adams et al., 2016). When they exhibit behaviors that transgress those standards, in contrast to their white counterparts they are labeled as “bad,” “ghetto,” or “ratchet” (Morris, 2016). African American women have endured a historical legacy of racism in the United States (Prather et al., 2018).

Living as an African American woman has been described by the term *intersectionality*, created by Crenshaw (1989), which refers to the convergence of

interlocking systems of oppression and structural inequalities (racism, sexism, classism) upon women of color (Williams & Lewis, 2019).

The origin of the intersecting modes of oppression for African American women is rooted in historical stereotypes of enslaved African American women subjected to white standards of beauty and womanhood. According to these invalid comparisons, African American women are inferior (Williams & Lewis, 2019). While enduring discrimination rooted in false perceptions of their inferiority, African American women also suffer the pressure of economic hardship and primary caregiving responsibilities (Watson & Hunter, 2015). African American women may feel that they are not valued, or that their value is less than that of their counterparts in the dominant white culture. Such feelings lead to a protective mode best known as the *Strong Black Woman* (*SBW*) schema. SBW is a race-gender schema stemming from slavery. It has prompted African American women to strive to exhibit extraordinary strength, self-reliance, and self-imposed silence when faced with hardships and stress (Watson & Hunter, 2015).

Analogous to SBW is the *Superwoman* role, a term originated by Woods-Giscombe (2010). This role has influenced many African American women's views on stress, strength, and health. The Superwoman role has five significant facets: an obligation to manifest strength, an obligation to suppress emotion, a resistance to experiencing or expressing vulnerability, a determination to be successful, and an obligation to help others. The Superwoman role can itself cause many stressors and promotes unhealthy coping habits, leading to the prevalence of mental health issues among women of color (Woods-Giscombe, 2010).

According to the Centers for Disease Control and Prevention [CDC], African American women reported slightly higher rates of depression than white, Asian, and Hispanic women ages 20 and older (Williams & Lewis, 2019). Racial and ethnic minorities exhibit lower rates of health care utilization than whites, especially mental health services (Cai & Robst, 2016). Apart from such stressors as financial disadvantage, lack of health insurance, and feelings of shame and guilt, African American people have a mistrust of clinicians (Boulware et al., 2003). This mistrust can be partially traced to the Tuskegee Syphilis Study conducted on African American men with untreated syphilis (without informing of their condition) from 1932 to 1972, as well as the legacy of the American physician Samuel A. Cartwright, who hypothesized in 1851 that "drapetomania" was a mental illness that drove enslaved Africans to flee captivity. These and many other incidences of unethical and immoral experimentation and derogatory treatment have caused the African American community to be reluctant to seek medical help, including mental health treatment. More African American women die while receiving care in hospitals than their white counterparts (Higginbotham, n.d.). With a historical lack of trust in white-dominated medical care, the African American community has turned to the Black churches for psychological help from the clergy and members of the congregation (Allen et al., 2010). Black churches (this study regards both *Black* and *African American* as appropriate terms; for purposes of concision and consistency, only the latter will be used to describe Americans of African descent) provided a positive influence and safe space for African Americans (Adkinson-Bradley et al., 2005), with religious worship as a method of coping instead of seeking help from medical professionals (Allen et al., 2010).

Purpose of the Study

The purpose of the study was to identify and examine the barriers experienced by African American women seeking mental health treatment. According to research, several barriers impede African American women seeking help. These barriers include economic and cultural concerns, such as accessibility, dependence on the Black church, and mistrust of medical professionals. This study examined how those barriers have led to different behaviors that influence African American women's perspectives on mental health, and how these perspectives may have changed over the years in successive generations. In addition, the study explored the coping methods that African American women typically use to alleviate stressors. It also offers an understanding of how African American women were taught to perceive mental health professionals and psychological treatment.

Research Questions

- What perceptions and attitudes toward mental health and mental illness do some African American women display that may influence and perhaps pose barriers to seeking professional mental health care?

- Have attitudes toward mental illness and mental health professionals changed among African American women over time?

CHAPTER 2: LITERATURE REVIEW

In May of 1962, Malcolm X delivered a speech containing the famous description of African American women as the most disrespected, unprotected, and neglected people in America. Many years have passed since Malcolm X's speech; however, his description of the adversity that African American women endure in this country remains pertinent. They have been denied the opportunity to thrive due to negative perceptions by other components of American society, and how those perceptions affect their views of themselves. Since slavery, African American women have been sexualized in denigrating ways, such as the jezebel or video vixen often displayed in hip-hop videos (Neal-Barnett, 2018) or as angry and aggressive (Epstein et al., 2017). These stereotypes are used to make the oppression of African American women seem natural and normal (Collins, 1991). African American women have worked diligently to overcome these pejorative images (Neal-Barnett, 2018). Because of their racial and gender identity, they are members of two oppressed groups (Settles, 2006), placing them a in a unique "double bind" in American society (Drakeford, 2019). As young girls, African American women learn to compromise their identity by straightening their hair or changing how they speak, as they navigate America's racial and gender prejudices (Jones & Shorter-Gooden, 2003). These unavoidable societal expectations cause many stressors, which lead to health and psychological issues that are too often left untreated (Schulz et al., 2000). This study examined the mental health challenges that many African American women face and the barriers that obstruct their attempts to seek help. Its initial focus is upon the challenges related to the roles imposed on women in America, especially African American women.

Gender Roles in Society

From birth, society molds and defines people according to their gender. For instance, it is common to assume that pink is a color for girls and blue is for boys (Eckert & McConnell-Ginet, 2003). Many little girls are socialized to play with dolls and become homemakers, and little boys are given trucks and directed toward becoming providers (Eckert & McConnell-Ginet, 2003). Girls and women are expected to show emotion and express their feelings. For these reasons, *Guidelines for Psychological Practices for Girls and Women* (2007) became a relevant topic of discussion because of the life experiences it describes.

According to the American Psychological Association (APA, 2018), gender includes assumptions, societal beliefs and norms, and stereotypes about boys' and girls' behaviors, cognitions, and emotions. These societal expectations are simply imposed on boys and girls without consideration for feelings of inferiority or stressors that may arise from the pressure to conform with gender roles. In the case of girls and women, such expectations contribute to their oppression by society, as well as to physical and mental health problems related to complex and diverse biological, psychological, and sociocultural environments (American Psychological Association, 2007). Women suffer disproportionately from mental health problems, including displaying depressive symptoms more often than men (Lewinsohn et al., 2001). Women are also subjected to male abuse and violence and are prone to low self-expectations, anxiety, and a lack of self-esteem (Brown & Keith, 2003).

Differences between Men and Women

Anatomically, men and women differ in chromosomal patterns, genitalia, and even brain activation (Ngun et al., 2011). According to Szalavitz (2013), women's brains are better able to integrate emotions and reason; men's brains have stronger links to coordinated action and perception. However, these differences extend much further than biological structure.

Men and women also display consistent differences in interests, activities, and social interactions (Byrd-Craven & Geary, 2007). Jancke (2018) found that cultural background, level of education, experience of gender equity, and gender stereotypes greatly influence cognition and emotions. Furthermore, as noted above, boys and girls are taught distinct gender-oriented behaviors that lead to different developmental experiences. These experiences prepare boys and girls for various tasks and roles that help to mold their sense of identity (Byrd-Craven & Geary, 2007).

Gender identity development is shaped by parents' and other adults' expectations about how boys and girls should behave and be treated (Basow, 2006). Girls and women have developmental and life experiences, such as menarche, fertility issues, pregnancy, childbirth, postpartum responses, and menopause. These experiences carry psychological, physiological, and cultural meaning (American Psychological Association, 2007). Young girls and women develop a healthy sense of self and gender identity through these experiences (Abrams, 2003). Moreover, girls and women may belong to multiple personal and social groups, simultaneously members of socially privileged or socially oppressed groups (American Psychological Association, 2007). Traits commonly associated with girls and women are being affectionate, emotional, friendly, sympathetic,

sensitive, and sentimental (Merchant, 2012). Socialization teaches girls to be submissive and nurturing (American Psychological Association Guidelines, 2007).

Girls and women make up 50.8 % of the United States' population (Census.gov, 2010). Women comprise half of the population, yet American society views them as inferior to men (Horowitz et al., 2017). The nation's history of sexism, misogyny, and patriarchal oppression is well documented. For decades, women were expected to stay at home and care for their families, which left women numbering only one-third of the workforce (Statusofwomendata.org, n. d.). Today, women are taking on more responsibilities and comprise more than half of the workers in the United State. Despite the significant advances that women have made in the United States, inequalities remain. A pay gap persists, with women earning less than men while performing the same work. For example, a white woman earns 79 cents to a man's dollar when both hold the same position (Gould et al., 2016). Available data show that African American women in analogous situations made just 64 cents to a man's dollar (Guerra, 2013). African American women constitute 13 % of the female population in the United States and have achieved impressive advances in education, health care, and other areas. However, a wide gap must still be closed to end racial and gender inequities (Guerra, 2013).

Developmental Beginning for African American women

For much of the early education of African American girls, they are subjected to *adultification* bias. This bias is a form of racial prejudice, in which children from minority backgrounds, such as African American girls, are viewed as more mature than they are by reasonable norms of social development (Perry et al., 2013). African American girls bear double the pressure in meeting the expectations of society. School is

where most development occurs for African American girls, and at that age, they already disproportionately face persistent and profound barriers to educational opportunities (Evans et al., 2001). A recent study found that African American girls experience an *age compression* (Morris, 2019), in which educators see them as more "adult-like" than their white peers (American Psychological Association, 2018; Epstein et al., 2017). Detrimental stereotypes are imposed on African American girls who are regarded as older than their age. Referring to a 10-year-old girl as a young woman does not describe who she will become; rather, its message to these girls is that they no longer are in the developmental stage and deserving of nurturance (Morris, 2019). An unfounded belief persists that African American girls know more about sex and participate in sexual activities at earlier ages than their white counterparts (Morris, 2019).

In schools, African American girls viewed as older than their years are held accountable with harsher punishments than those applied to other girls, an inequity that recalls the racist sentencing policies of the criminal justice system (Morris, 2019). In fact, in the 2016-2017 school year for the Baltimore district, more African American girls were arrested by school police in incidents involving excessive force and aggressive, threatening behavior by the arresting officers than any other students (Morris, 2019). African American girls are disrespected for their communication styles. Being loud or outspoken is deplored in school, but for African American girls, it is a way to speak up and be heard (Morris, 2019). Schools have created dress codes that ban hairstyles associated with African American culture, like cornrows and afros (Morris, 2019). With school playing a vital role in a young girl's life, it is hard for them to believe that what they learn or observe in that environment is not accurate. Therefore, these harsh

perceptions and policies impact African American girls negatively, imposing upon them an inauthentic identity that has been created for them.

Many African American women feel pressure to compromise their authentic selves as they navigate America's racial and gender bigotry (Jones & Shorter-Gooden, 2003). Historically, the United States has developed an *American Collective Identity* that excluded African Americans (Kook, 1998). African American women should be internally individualized yet also share identification with their subgroup (Lamont & Molnár, 2001). Conflict arises when others do not acknowledge them as individuals or permit their identity to emerge (Lamont & Molnár, 2001). Conflict forces compromise, and African American women compromise by *shifting*. Shifting entails altering their external appearance or the expectations they have for themselves (Jones & Shorter-Gooden, 2003). For example, African American women may modify their speech or straighten their hair. Many African American women shift to approximations of white behaviors in public settings and shift back when at home (Jones & Shorter-Gooden, 2003). The delineation of shifting is a much-needed, clear, and comprehensive portrait of the reality of African American women's lives today (Jones & Shorter-Gooden, 2003).

Intersectionality

Due to their social, racial, and gender identities, African American women experience a unique form of systemic oppression (Moody & Lewis, 2019). Crenshaw (1989) labeled this experience intersectionality. Intersectionality is defined as the interconnected nature of social classifications, such as race, class, and gender in an overlapping and interdependent structure, and how it affects an individual or group in terms of discrimination or disadvantage (Rogers et al., 2013). For example, an

African American woman lives in the intersection two oppressed groups. Crenshaw (1989) utilized the theory of intersectionality as a lens for viewing the exclusion of African American women from white feminist discourse.

Intersectionality is manifested in economic disadvantages in many segments of the job market. African American women are disadvantaged by their exclusion from the financial, economic, and educational experiences available to their white counterparts. According to Morris (2016), 25% of African American women live in poverty. This high rate of poverty results in part from an 8.2% unemployment rate for African American women compared to 4.4% for white women (Morris, 2016). When African American women are employed, they often earn low wages in occupations that pay less than $21,412 a year (Morris, 2016). In addition, statistics show that African American women are disproportionately dependent on welfare (Morris, 2016).

Strong Black Woman Schema, Superwoman, and Sisterella

African American women have assumed varied and multifaceted roles socially and personally. One positive characteristic frequently ascribed to African American women is strength. Abrams et al. (2014) pointed out that many African American women become strong mentally, physically, and emotionally because of the difficult circumstances they constantly face. African American women are often obliged to assume multiple roles as financial providers and caregivers for themselves and their families (Abrams et al., 2014). By necessity, African American females are socialized from an early age to exhibit strength, self-reliance, and stoic silence when faced with stress (Watson & Hunter, 2015). The expression of negative emotions is often considered a sign of weakness and inadequacy (Abrams et al., 2014; Beauboeuf-Lafontant, 2007).

The strength frequently projected by African American women is the salient characteristic of a schema termed the *Strong Black Woman* (SBW), a term conceptually interchangeable with the *Superwoman Schema* (Woods-Giscombé, 2010) and the *Sisterella Complex* (Jones & Shorter-Gooden, 2003). The Strong Black Woman schema dates back to slavery and persists due to the struggles that African American women endure from financial hardship, primary caregiving responsibilities, racism, and sexism (Watson & Hunter, 2015). The schema includes five modes of obligation: to display strength, to suppress emotion, to resist vulnerability, to strive to succeed despite a lack of resources, and to feel a need to help others (Manke, 2019). Conceptualized as an idealized icon, in actuality the schema is a deleterious cultural syndrome (Etowa et al., 2017). The Strong Black Woman, Superwoman, and Sisterella roles are ubiquitous among African American women. Being perceived as a Strong Black Woman has encouraged African American women to persevere amid obstacles and to handle those challenges alone, not depending on others (Watson & Hunter, 2015). African American women internalize early in life the message that they should not rely on others for their needs (Etowa et al., 2017). However, the internalization of the SBW schema has been associated with adverse psychological outcomes (Liao et al., 2019).

Stressors

Many African Americans are disadvantaged socially and economically, and numerous studies have indicated that African Americans are exposed to substantial levels of stress and adversity over their lifetimes (Hudson et al., 2016). Exposure to stress can contribute to the development of health disorders, including mental illness. Racial discrimination is a primary stressor related to increased depressive symptoms and greater likelihood of depression (Hudson et al., 2016).

To explain the etiology of stress among African American women, theorists have examined the biological elements of stress pertaining to skin color, hormones, and age, as well as environmental factors such as social class, discrimination, racism, and sexism (Giurgescu et al., 2013).

Societal Stress

Racism is typically conceptualized as a psychosocial stressor (Nuru-Jeter et al., 2009). For African Americans, racism generally is a source of chronic strain and psychological distress (Perry et al., 2013). According to Perry et al. (2013), many studies have documented the pernicious influence of various forms of racism and discrimination on mental health and wellbeing.

Jackson and Sears (1992) found that social roles are not equally rewarding or distressing to all social groups, and individuals may not benefit from the same combinations of roles (Davis et al., 2011). Social roles usually do not exist in isolation; they spill over into other social roles that one performs (Davis et al., 2011). Spillover leads to one role expanding to affect the quality of another role positively or negatively (Davis et al., 2011). In particular, African American women tend to suffer more work-related consequences of the strain of parental roles than men (Davis et al., 2011). The demands on women in the home are more likely to interfere with their work responsibilities than those placed on men (Davis et al., 2011). Although the social status of gender is imperative to consider in examining role performance and psychological wellbeing, research has found that race is another powerful influence.

Health-Related Stress

One in four African American women lacks health insurance, which with other socioeconomic factors continues to exacerbate the severe health issues African American women experience (Guerra, 2013). Hypertension is more prevalent among African American women than in any other group of American women (Guerra, 2013). Of American women ages 20 and older with hypertension, 46 % are African American, compared to 31 % of whites and 29 % of Hispanics (Guerra, 2013). Moreover, African American women comprise 65 % of new AIDS diagnoses among women (Guerra, 2013). African American women are three times more likely to have unplanned pregnancies, and four times more likely to die from pregnancy-related causes like embolisms and hypertension than any other racial or ethnic group of American women. Although white women are more likely to suffer from breast cancer, African American women have higher death rates from breast cancer (Guerra, 2013). Every year, 1,722 African American women die from breast cancer, a rate of approximately five deaths per day (Guerra, 2013). Moreover, the rates of human papillomavirus and cervical cancer in African American women are double those of white women (Guerra, 2013). African American women's psychological and physical health problems are linked to chronic and acute stressors associated with sexism (Perry et al., 2013).

Psychological Stress

The unique health problems of African American women are associated with their exposure to racism, sexism, and gendered racism (Drakeford, 2019). These multiple forms of oppression leave African American women exposed: to low-income jobs, to physical and psychological strain, and to an array of health problems, all of which are

risk factors for mental illness (Ward & Heidrich, 2009). Drakeford (2019) asserted that an urgent need exists to focus intently on the mental health of African American women, especially when they report feelings of sadness and worthlessness, and the sense that their daily struggle far exceeds the experience of white women. According to the CDC, African American women suffer higher rates of depression, as well as greater severity of depression, because of racial and gender discrimination (Williams & Lewis, 2019). Approximately 7.5 million African Americans have a diagnosed mental illness (Ward & Heidrich, 2009). Drakeford (2019) also noted that African American women exhibit lower rates of seeking psychological help than women of other racial/ethnic groups. An epidemic of untreated and poorly treated depression afflicts the United States, especially among African Americans (Waite & Killian, 2008). Only 16% of African Americans with mental illness receive treatment of any kind of treatment (Waite & Killian, 2008). Watson & Hunter (2015) observed that this deficit would lead more African American women to suffer from higher rates of anxiety and depression, which can intensify when combined with negative thoughts about seeking mental health help from professionals.

Mental Health Services Addressing Common Mental Health Concerns in the African American Community

As of 2018, 11,682 registered mental health treatment facilities were in operation in the United States (Elflein, 2019). Effective treatment for anxiety and depression can help patients to overcome symptoms.

Culturally Adapted Treatments/Interventions

More recent studies have found that culturally adapted treatments and interventions effectively reduce mental health symptoms (Ward & Brown, 2015).

Culturally adapted treatments and interventions are modifications of evidence-based mental health treatments that entail changes in approach to service delivery, the nature of the therapeutic relationship, or in aspects of the treatment itself to accommodate the cultural beliefs, attitudes, and behaviors of the target population (Ward & Brown, 2015). The importance to African American culture of such features as spirituality, Black identity, and African American family relationships illustrates that an understanding of their culture is essential to success in therapy. Mental health interventions targeting specific cultural groups have proven four times more effective than generalized interventions provided to culturally diverse groups of clients, which indicates that treatment tailored to a specific cultural context may yield optimum benefits (Ward & Brown, 2015).

Cognitive Behavioral Therapy (CBT)

According to the APA (2017), *Cognitive Behavioral Therapy* (CBT) is a form of psychological treatment that has demonstrated its value in alleviating various mental health problems, including depression and anxiety. It can significantly improve functioning and quality of life (APA, 2017). CBT is a problem-oriented strategy focusing on finding solutions to the patient's current issues ("Cognitive behavioral therapy," 2013). CBT posits that thoughts and emotions contribute to feelings and behaviors. Throughout the course of treatment, CBT identifies, challenges, and replaces maladaptive thoughts and behaviors through several techniques. Because CBT is dedicated to restructuring dysfunctional cognitions, it may dispel African American women's misgivings about seeking and receiving therapy and help them to shed behaviors they have learned.

Interpersonal Therapy (IPT)

Interpersonal therapy (IPT) is a time-limited, empirically validated treatment for mood disorders completed in 12-16 weeks (Markowitz & Weissman, 2004). This therapy is used when a disturbing change emerges in a patient's interpersonal environment, and symptoms compromise interpersonal functioning. (Markowitz & Weissman, 2004). After diagnosis, IPT identifies the patient's relevant interpersonal relationships. The therapist empathically engages with the client, arouses affect, presents a clear rationale and treatment plan, and builds a therapeutic alliance with the client. (Markowitz & Weissman, 2004). Clients are tasked with resolving those disturbing life events, building social skills, and organizing their lives. If those life problems are resolved, depressive symptoms can be resolved as well. Moreover, for African American women, discussing the societal and systemic discrimination they face due to intersectionality may be beneficial. If African American women have learned to cope with and overcome discrimination, they can apply those skills to coping with mood states such as depression and anxiety.

Group Therapy

According to the American Psychological Association (2019), therapeutic groups are designed to target specific problems, such as depression, or to focus on improving skills that help group members deal with a range of issues, like loneliness or low self-esteem. The benefit of groups is as a support network, in which members can help each other develop specific strategies for overcoming challenging life situations and hold each other accountable (APA, 2019). Also, groups allow individual members to put their problems into perspective by talking and listening to others (APA, 2019). It is helpful for African American women to become a part of a group of people who share some of the

same challenges. The women in the group create relationships that provide mutual support and pool resources that members can draw on to overcome challenges and bear hardships without feeling alone.

Acceptance and Commitment Therapy (ACT)

According to Heydari et al. (2018), *Acceptance and Commitment Therapy* (ACT) has successfully reduced anxiety and depression. Accepting problems and coping with anxiety can improve health (Heydari et al., 2018). According to Webster (2011), ACT has six core components that combine the processes of acceptance and mindfulness with commitment and behavioral change to increase psychological flexibility and expand the patient's range of behaviors. The six core components are Acceptance, Diffusion, Present Moment, Self as Context, Values, and Committed Action (Fung, 2015). The first three steps entail accepting feelings without immediate reaction, becoming aware of all thoughts and emotions in the present moment, and learning to separate oneself from subjective experiences and act independently of their influence (Heydari et al., 2018). The last three steps focus on efforts to reduce the excessive influence of visualization or self-created personal stories. Instead, an individual identifies fundamental and essential values, transforms them into specific behavioral goals, and acts to realize those goals as expressions of their essential values (Heydari et al., 2018).

Medication

Along with psychotherapy, medication is another means of treating mental illness. According to the APA (2017), medication, psychotherapy, and a combination of both have demonstrated a capacity to help people with emotional or behavioral problems. Medications are particularly helpful in the management of symptoms (McMillan et al.,

2020) through altering brain neurochemistry (Shaddel et al., 2015). Several types of medication can ease anxiety and depression. According to the National Alliance on Mental Illness, medication alleviates symptoms so that other aspects of the treatment are effective. Therefore, choosing the optimum combination of treatments based on the needs of the individual is crucial. For example, reducing depressive symptoms like lack of energy with medication allows an individual to participate in psychotherapy more effectively.

Barriers to seeking Professional Mental Health Treatment

Despite the many stressors that African American women encounter, they consistently continue to manage their lives effectively. For African American women, experiencing multiple forms of stress does not warrant seeking help.

Lack of Mental Health Literacy

Mental health literacy (MHL) is a construct that was developed from the domain of *health literacy* (HL), which stemmed from the observations of low functional literacy that are associated with many adverse health outcomes (Kutcher et al, 2016). The HL model focused on how effectively people understood and used medical information in order to achieve better adherence to treatment (Kutcher et al, 2016). MHL applies this same idea to adherence to mental health treatment. According to O'Connor and Casey (2015), who cited Jorm et al. (1997), MHL consists of the knowledge and attitudes that individuals possess regarding mental health that aid in the recognition, management, and prevention of mental health problems. Jorm et al. (1997) posited that MHL has seven attributes: the ability to recognize specific disorders, knowledge of how to seek mental health information, knowledge of risk factors and causes, knowledge of self-treatment,

knowledge of the professional help available, recognizing one's need for professional help, and seeking help appropriately. The research also indicated a low level of knowledge about mental health in the African American community (O'Connor & Casey, 2015). It is important for MHL to be applicable to everyday life situations, adaptable across a lifetime, and integrated effectively into existing social and organizational structures like community organizations (Kutcher et al, 2016). When applied appropriately, MHL interventions can be evaluated in order to improve the components of the construct, including expanding mental health awareness, improving attitudes and eliminating stigma, and encouraging help-seeking behaviors (Kutcher et al, 2016).

In the effective implementation of MHL, challenges arise for several reasons. One reason is that a gap exists between public and professional beliefs about treatment (Jorm et al, 2006). For example, mental health professionals have reached a consensus about treatments that are appropriate for depression and schizophrenia (Jorm et al, 2006). However, the public's views do not align with the professional consensus concerning the use of medication to treat mental illness and admission to a psychiatric facility (Jorm et al, 2006). According to Jorm et al (2006), another challenge derives from the stigma the public attaches to both to mental illness and treatment for it. This includes self-stigmatization, in which a person will apply internalized negative attitudes of society to themselves (Jorm et al, 2006). Mental health first aid is a challenge, because too few are trained in the necessary skills (Jorm et al, 2006). Because African American communities exhibit a high rate of mental illness, a community's response to efforts to treat mental illness poses another challenge (Jorm et al, 2006). According to Jorm et al (2006), the response indicates whether a person will seek and receive professional help and feel

supported by their family, friends, and community. The array of challenges faced by African Americans has led to failures to seek appropriate care and adhere to recommended treatment, which undermines the possibility of successful outcomes (Jorm et al, 2006). Higher levels of MHL are associated with greater intentions of identifying risk and seeking help (O'Connor & Casey, 2015).

Mistrust of Medical Professionals

African American people have a mistrust of clinicians (Boulware et al., 2003). Their mistrust stems from the horrific legacy of inhumane treatment of African Americans by slave owners, physicians, and the United States Public Health Services.

Between 1846 and 1849, Dr. J. Marion Sims practiced medicine in Alabama (Lynch, 2020). His specialty was gynecological surgical procedures, particularly closing vesicovaginal fistulas (Lynch, 2020). These early surgical procedures led to Dr. Sims being hailed as the "Father of Gynecology" (Wall, 2006). During this period, slave owners faced very high death rates in the enslaved population, and Great Britain's Royal Navy had ended the trans-Atlantic slave trade. Therefore, the existing population of enslaved Africans in America's slave states became the sole source of new slaves, not just to replace the dead but to expand the enslaved workforce for the labor-intensive cultivation of cotton, the South's most profitable crop. When their female slaves suffered from reproductive and gynecological disorders, the slave owners relied on Sims to preserve their reproductive potential (Vernon, 2019). The slave owners' dependence on Sims enabled his abuse of his patients and his unethical experimentation upon powerless African American women. Slaves were chattel, without legal rights (Wall, 2006). Sims did not use anesthesia during his surgeries on African American women (Lynch, 2020).

His decision not to use anesthesia or any other means to alleviate pain derived from on the misguided belief that African Americans did not experience pain (Lynch, 2020). Sims completed surgeries on 11 enslaved women (Vernon, 2019). Of the 11 women, research has identified three by name, Anarcha, Betsey, and Lucy (Vernon, 2019). Sims operated repeatedly on these women, some as many as 30 times (Vernon, 2019). Research revealed that Lucy almost died after one procedure and needed two to three months to recover, because a sponge used to drain her urine was left in her body (Ojanuga, 1993). Despite that result, Sims continued to conduct the surgeries (Vernon, 2019) and moved his practice to New York City (Lynch, 2020). According to Lynch (2020), Sims opened a women's hospital in the late 1850s and began treating white women; however, he employed anesthesia with these patients.

J. Marion Sims is important to the development of surgical treatment of the vesicovaginal fistula. He is more important as an example of a physician who exploited slavery to further his career and abused African American women without regard for their suffering (Ojanuga, 1993).

Sims is, sadly, far from alone in his exploitation and abuse of enslaved African Americans. Dr. Samuel A. Cartwright, a Louisiana surgeon and psychologist, coined the terms "Drapetomania" and "Dysaesthesia Aethiopica" to describe slaves' desire to escape to freedom and their avoidance the demands of forced labor, respectively (Eakin, 2000; Myers, 2014). According to Eakin (2000), Cartwright saw slavery as normative, so when slaves deviated from the norm, he deemed them mentally ill. Rather than viewing African American's desire for freedom as purposeful and rational, he defined it as a mental illness to which all African Americans were predisposed (Myers, 2014). Cartwright wrote that

drapetomania was treatable and could be prevented almost entirely with the aid of proper medical advice (Eakin, 2000). According to Alvin Poussaint, Cartwright's hopelessly unscientific diagnosis was more than just an historical oddity. It vividly illustrates how definitions of normal and abnormal behaviors are shaped by the values of the society in which they originate (Eakin, 2000). In addition to his concocted diagnoses, Cartwright assembled statistics and diagnostic categories in the hope of convincing whites to limit African American mobility, to eliminate power sharing, and to reduce all African Americans to slavery (Myers, 2014).

One of the most compelling reasons for African American to mistrust the medical establishment was the Tuskegee Syphilis Study, which was conducted on African American men with untreated syphilis for 40 years, from 1932 to 1972. The Tuskegee Experiment, as the study is also called, left the African American community reluctant to seek medical help, including mental healthcare. According to the CDC, the Tuskegee Syphilis Study involved 600 African American men, 399 with syphilis and 201 who did not have the disease. This research was conducted without informed consent, and the men were told that they were being treated for "bad blood," a folk-based blanket term describing several ailments (CDC, 2015). The men were denied treatment for the disease, even after penicillin was accepted as a highly effective treatment for syphilis (CDC, 2015). The study continued until exposure by journalists triggered widespread public outrage. The revelation of the Tuskegee Syphilis Study demonstrated to African Americans how little the government and the medical establishment seemed to value their lives, and prompted the African American community to avoid trusting in medical professionals for fear that they would be misled and mistreated.

A case more specific to women is that of Henrietta Lacks. In 1951, Lacks went to Johns Hopkins Hospital complaining of vaginal bleeding, and a tumor was found on her cervix (Lyapun et al., 2018). According to Skloot (2010), Johns Hopkins was one of the only hospitals that treated impoverished African Americans at that time. Lacks underwent radiation treatment. As part of the treatment, doctors performed a biopsy of her cancer cells. Such cells typically died quickly, but Lack's cancer cells were different (Lyapun et al., 2018). Instead of dying, her cells doubled every 20 to 24 hours (Khan, 2011). Lack's cancer cells, named HeLa cells, were highly beneficial to medicine, enabling discoveries about the effects of toxins, drugs, hormones, and viruses on the growth of cancer cells without experimenting on humans. They even played a significant role in the development of the polio vaccine (Lyapun et al., 2018). Nearly 11,000 patents involve HeLa cells (Khan, 2011). Although these discoveries derived from the utilization of Lack's cells, she was never notified that her cells were being used, nor was she or her family ever compensated for her contributions to medicine (Lyapun et al., 2018). Her family did not know about the research based on her cells until more than 25 years later (Khan, 2011). The doctors at Johns Hopkins took advantage of Henrietta's condition and ignored her right of consent to their use of her cells (Lyapun et al., 2018).

The historical narrative concerning the racial inferiority of African Americans has exacerbated discriminatory health care practices, negatively affecting the quality and types of health care provided to African American women (Prather et al., 2018). Today, African American women often receive discriminatory care in hospitals. Ana Langer (2019) published an article reporting that in hospitals, African American women were undervalued and were not monitored as carefully as white women. Even when they

presented with symptoms, their symptoms were often dismissed. According to Higginbotham (n.d.), research conducted in 2016 found that more African American patients died in critical care units than white patients. This research also observed that white doctors tended to stand further from the bedside of patients of other races or ethnicities (Higginbotham, n.d.). This behavior and treatment are deeply rooted in American culture, and younger physicians are learning and perpetuating the biased ways of their elders (Higginbotham, n.d.).

Accessibility

Accessibility to mental health services for African Americans is poor in terms of the availability of care and high costs, as well as disparities in the quality of care received by African Americans (Noonan et al., 2016). According to Cai and Robst (2016), racial and ethnic minorities have lower rates of health care utilization than their white counterparts, particularly mental health services. In 2010, the Patient Protection and Affordable Care Act was created to help those with financial hardships receive health care services, including mental health and substance abuse treatment (Cai & Robst, 2016). However, several sociologists and epidemiologists have found that a neighborhood is a critical variable mediating access to economic opportunities, social connections, and social capital, which are factors that influence access to health care (Mays et al., 2007). Poorer communities lack adequate health and social services, compounding the problems of access and timely care (Mays et al., 2007). Also, according to Mays et al. (2007), the concentration of poverty and related ills, such as drug use and trafficking, gangs, and endemic violence, often creates environments that diminish social connectedness and provide fewer social benefits like mental health care for residents.

Disparities exist in mental health care services, and African Americans often receive poorer quality of care and lack access to culturally competent professionals (American Psychological Association, 2017). Research has indicated that African Americans' reluctance to resort to the mental health care available to them has contributed to significant unmet mental health needs (Ward & Brown, 2015). The inequalities that affect African Americans in this country arise from many sources, not only cultural differences in lifestyle but inherited health risks and social inequities that are manifested in differences in socioeconomic status, access to health care, and variations in health providers' behaviors (Mays et al., 2007). Clinicians providing services for African Americans are decreasing the availability of proper care for African American women. Research has revealed deterioration in the condition of African Americans from mental health treatment programs that were not culturally specific (Ward & Brown, 2015). Therefore, African American women and people of color viewed controlling their health as a corrective to the failures of white, patriarchal medical systems to meet their needs (Harris, 2017). A better understanding of the factors that influence the mental health of African American women may indicate the cultural interventions needed to increase the quality of health care for this population (Drakeford, 2019).

Mental health treatment offices are not always welcoming places for African American women. Princeton University doctoral student Heather Kugelmass's 2016 study of race, class and therapist availability showed that therapists were three times less likely to schedule appointments for working-class persons seeking help than for middle-class persons, regardless of race. Furthermore, African Americans in the middle-class

group were less likely to be scheduled for appointments than whites in the same group (Pappas, 2021). Other obstacles that African American women may face when seeking mental health care are that they may struggle to find a licensed professional mental health therapist, and they may have even more difficulty finding one who looks like them. According to APA's Center for Workforce Studies, only 4% of psychologists in the United States are African American (Lin et al., 2018).

Use of Self-Medication

African Americans who feel that they are mistreated and discriminated against are more likely to rely on illegal drugs and alcohol as means of coping (Hunte & Barry, 2012). Those who have experienced discrimination and perceived it as highly stressful were more likely to smoke cigarettes than those who had not experienced discrimination (Landrine & Klonoff, 1996). Borrell et al. (2007) found an increased lifetime use of marijuana and cocaine among African Americans who had experienced discrimination. Researchers have proposed that substance use and abuse are self-soothing behaviors for individuals who are psychologically distressed (Hunte & Barry, 2012). According to Hunte and Barry (2012), individuals will manage emotional pain and anxiety with alcohol, cigarettes, and illicit drugs in order to find emotional stability.

Alternatives to Seeking Professional Mental Health Treatment

The alternatives to seeking professional mental health treatment are methods that African American women commonly use to cope with everyday life stressors. Some alternatives provide a sense of belonging to groups who share some of the same experiences. Research shows that African American women cope with racism and sexism

through connection with loved ones and by drawing strength from spirituality and stories of their African American ancestors (Shorter-Gooden, 2004). Other alternatives include the church, informal support groups, and self-help skills. The church and informal support groups provide the opportunity to be a part of a close-knit community. Because these groups are not run by mental health professionals, confidentiality is uncertain. Self-help models of care lack the sense of building alliances and relationships, as well as the connections with people with similar experiences who can share how they developed ways to cope.

The Black Church

According to Sahgal and Smith (2009), the United States is a highly religious nation. However, African Americans are markedly more religious than the United States' population as a whole. For the African American community, religion and spirituality are vitally important. Because of the impact of slavery, racism, and oppression that shaped the Black church, religion provides a different experience for African Americans than it does for other ethnic groups (Adksion-Bradley et al., 2005). Known as the oldest and most influential organization founded, maintained, and controlled by African Americans, the Black church was the center of social life, providing fellowship, friendship, and moral support, and offering a sense of belonging (Adksion-Bradley et al., 2005). The Black church has been a positive and safe space for African Americans (Allen et al., 2010). Often described as the pulse of the African American community, the Black church tended to social, psychological, and spiritual needs (Adksion-Bradley et al., 2005). Compared to other racial and ethnic groups, African Americans are the most likely to report a formal religious affiliation, with 87% belonging to a religious denomination

(Sahgal & Smith, 2009). Surveys have discovered that older generations of African Americans are more religious than younger generations (Diamant & Mohamed, 2018; Sahgal & Smith, 2009). For example, approximately one in five African Americans under the age of 30 (19%) are unaffiliated, compared to only 7% of African Americans who are 65 and older (Sahgal & Smith, 2009). Research found that based on a four-item scale including *belief in God*, self-described *importance of religion*, *prayer*, and *worship attendance*, 64% of African American millennials are highly religious (Diamant & Mohamed, 2018). Some 61% of African American millennials said they pray daily, and 38% attend religious services weekly (Diamant & Mohamed, 2018). Compared to 71% of older African Americans, 61% of African American millennials felt a deep sense of spiritual peace and wellbeing (Diamant & Mohamed, 2018). According to Diamant and Mohamed (2018), African American millennials were less likely to engage in religious activities in addition to regular religious services. They were less likely than older African Americans to say they pray daily, attend religious services weekly, and religion is important to them (Diamant & Mohamed, 2018).

Spirituality has been a buffer against stressful events, which has helped people to overcome difficulties (Krok, 2008). Since the 1990s, findings consistently indicate that religious participation protects against premature mortality, which increases longevity (Levin et al., 2005). Studies have explored the influence of religion on measures of positive wellbeing, notably satisfaction with life and happiness (Levin et al., 2005). According to Krok (2008), strong relationships obtain between spirituality and coping. Many individuals search for spiritual guidance during stressful life events, using spiritual practice as a means of support. According to Sahgal and Smith (2009), nearly 79% of

African Americans reported that religion is significant in their lives. Based on the *Self-Description Questionnaire of Spirituality and the Coping Inventory for Stressful Situations,* research has established three dimensions of spirituality: religious attitudes, ethical sensitivity, and harmony (Krok, 2008). Each of them plays a significant role in coping processes, with different impacts on particular processes, depending on the internal structure. An analysis of national data revealed an advantage for African American due to religious participation (Levin et al., 2005). Overall, spirituality is associated with task-oriented and social diversion coping, which means those who have a high level of spirituality will try to solve problems through efforts aimed specifically at resolving them or through social support (Krok, 2008).

African Americans typically seek support from pastors or ministers when having personal crises; in fact, they are often the only professionals consulted (Allen et al., 2010). The Black church provides religious coping mechanisms like prayer, altar calls, and music, because seeking outside help is viewed as a failure of faith in God (Allen et al., 2010). African Americans pray more frequently than the general population (Sahgal & Smith, 2009). According to Jackson & Sears (1992), prayer was the most important coping response among African Americans, although more so with women than men. Therefore, given the great trust that African Americans place in religion, clergymen play a significant role in advising members of the congregation to seek help beyond what the church can offer (Allen et al., 2010). Clergy members are the gatekeepers to care by mental health professionals for an underserved population (Allen et al., 2010).

Support Groups

A recurrent theme found in many treatment studies is that African American women find it important to have the support of other African American women (Neal-Barnett et al., 2011). According to Neal-Barnett et al. (2011), *sister circles* have been an important part of African American life for the past 150 years. Sister circles consist of mutually supportive African American women; that support can be helpful, even healing, for women experiencing anxiety or panic (Neal-Barnett et al., 2011). These groups build upon existing friendships, fictive kin networks, in which close friends are regarded as family, and the sense of community found among African American women (Neal-Barnett et al., 2011). *Sister friends* are analogous groups that emerged with sister circles. Sister friends offer vital assistance as African American women face and overcome major challenges, including stress and traumatic stress (Bryant-Davis, 2017). According to Pappas (2021), these circles are a way to expand mental health access in African American communities, because they are embedded in churches, sororities, and other organizations. Sister circles provide African American women with support, knowledge, and encouragement (Neal-Barnett et al., 2011). These circles are sponsored by African American churches, sororities, educational institutions, and community agencies (Neal-Barnett et al., 2011).

Over the years, sister circles began to represent different things to different groups of women (Neal-Barnett et al., 2011). Sister circles have evolved from organizations like churches to focus on issues that women share, such as health concerns like breast cancer, and come together for education and support (Neal-Barnett et al., 2011). The concept has even been modified for use with adolescent African American girls (Neal-Barnett et al.,

2011). Many of the groups center around African culture and incorporate elements that are unique to African American women's lives (Neal-Barnett et al., 2011).

Self-Help

African American women utilize self-help tools, such as books and podcasts, to implement self-care. According to Adkins-Jackson et al.,(2019), the practice of self-care involves several activities that can potentially impact the health and wellbeing of individuals. Some popular self-help tools are the books of Iyanla Vanzant and the *Therapy for Black Girls* podcast. These self-help tools aid in developing resilience and in buffering the impact of stress (Adkins-Jackson et al., 2019). Self-care helps build self-awareness, creating ways to correct imbalance and sustain equilibrium (Adkins-Jackson et al., 2019). The term self-care has crossed over into the mainstream and through the Women's Movement and Civil Rights Movement, self-care became a political act (Harris, 2017). In the 1960s and 1970s, self-care was redefined in the United States as methods to alleviate and better cope with stress for people with taxing occupations (Hickson & Blumenthal, 2019). According to Hickson and Blumenthal (2019), self-care is the practice of taking an active role in protecting one's happiness and wellbeing during periods of stress. For millennials, self-care takes many forms, such as journaling, yoga, facials, etc. (Hickson & Blumenthal, 2019). More millennials reported making "personal improvement commitments" than any generation preceding them (Hickson & Blumenthal, 2019). In 2015, millennials spent twice as much as baby boomers on self-care necessities. The attention paid to the self-care movement in recent years may eventually lead to the effective use of mental health services available to treat increased mental health needs.

Summary

In summary, many African American women have been taught at a young age that they should avoid seeking professional mental health care. They have inculcated the cultural imperative to be strong, and what it means to be strong for an African American woman. As African American women, they have roles that require them to be strong in their family, job, and community. This need for strength prevents them from expressing emotion, because to do so is viewed as weakness by other African Americans and themselves. With the emphasis on strength comes a reinforcing belief: They have no one turn to if they are not strong.

The need to be strong is one of the barriers that forestall help-seeking behaviors in African American women. As a result, African American women typically rely on other coping methods, including going to church, praying, sister circles, and self-help guides.

CHAPTER 3: METHOD

This qualitative study collected information through a demographic questionnaire and a semistructured interview with African American women. This design was chosen because of the rich data that this research discovered concerning how and why African American women develop views that lead them to not seek help from mental health professionals. Qualitative research, sometimes called “hypothesis-generating research” (Auerbach & Silverstein, 2003), is used to understand people's beliefs, experiences, attitudes, behaviors, and interactions (Pathak et al., 2013). This form of research has two distinct principles: using questions instead of variables and generating hypotheses through theoretical sampling and coding (Auerbach & Silverstein, 2003). *Grounded theory* has developed a process of revealing information to garner knowledge in an area that lacks research. It proposes that the only way to gain further knowledge and understanding is through the interactions and experiences of the participants. The participants become the experts on the matter under investigation. Sharing their subjective experiences leads to the generation of hypotheses to explain the matter.

Participants

The study sample included 25 participants from three different generations. The participants’ ages ranged from 18- 51, divided into these groups: Generation Z (18- 24), Generation Y (Millennials, 25-39), and Generation X (40-54). Two potential participants were excluded from the study, because they did not meet the inclusion criteria. Participants were recruited primarily through social media accounts and flyers. Some

snowballing occurred, which yielded more participants. Recruitment began in January 2021 and ended in February 2021.

Inclusion and Exclusion criteria

The participants were prescreened according to the following eligibility criteria: Each participant must self-identify as biologically female, of African American descent, and at least 18 years of age but not over 54 years of age.

Potential participants were excluded from the study because they failed to meet the age criterion.

Screening and Recruitment

To conduct this study, the Institutional Review Board (IRB) of the Philadelphia College of Osteopathic Medicine granted approval. The researcher posted information about the study on the researcher's various social media accounts (see Appendix A) in places frequently visited by African American women (i.e., churches, hair salons, nail salons, etc.), and prospective participants shared the information with other women. Along with the information posted, a link was provided for interested women to read and complete a demographic eligibility screener (see Appendix B).

Measures

Semistructured interview

The semistructured interview (see Appendix C) consisted of 10 open-ended questions developed by the researcher. This 30-minute interview was designed to elicit the participants' perspectives on mental health and illnesses. They were asked how they learned about mental illness, and what they have been taught about mental illness, both positive and negative. They were asked if they had been diagnosed with mental illness, or

if they had ever encountered someone with mental illness. If they had, participants were asked to describe their reaction to that experience. Another question asked what support they had in place for coping with stressful situations and to describe their experience with receiving help. Other questions inquired about barriers the participants perceived to seeking professional help, and how their physical health differed from their mental health. The final question asked if the Black Lives Matter movement and recent national events involving race had affected their mental health and made them feel that they needed treatment. Supplemental questions were added as necessary during the interviews. The ten questions were developed to gain insight into the impact of the African American experience on contemporary African American women seeking professional mental health treatment.

Demographic questionnaire

The researcher developed the demographic questionnaire. It was designed to facilitate the recruitment process by gathering background information about potential participants interested in the study to determine whether each met the inclusion criteria. The demographic questionnaire collected data pertaining to ethnicity, gender, age, education, income, insurance, residence, children, partners, profession, and support systems. To examine the questionnaire, please see Appendix B.

Procedure

The date and time for the interviews were scheduled after the participants were selected. The researcher provided a statement of informed consent to the participant. Each participant chose a pseudonym, which kept their identity confidential and ensured anonymity. Because this study is qualitative in nature, the interviews were recorded and

transcribed in order to process results. When the interviews were completed, each participant was debriefed and given information about African Americans and mental health. The researcher also informed each participant that if they wanted a copy of the study's findings, it would be available to them. After each interview, the audio recording was stored and locked until transcription took place. The audio recordings were transcribed by the researcher and erased immediately after transcription. The transcriptions, signed informed consent documents, and completed questionnaires were kept in a locked file cabinet in the researcher's office.

The researcher then recruited two coders to help with identifying themes from the participants' transcribed interviews. The coders were two doctoral students at Philadelphia College of Osteopathic Medicine, and the team met three times during the process. In the first meeting, the researcher provided the coders with training in qualitative studies and the coding process. After the training was completed, both coders received a copy of the 25 transcribed interviews to begin the coding process. The original transcripts involved 25 females, two from Generation Z (18-24), 15 from Generation Y (25-39), and eight from Generation X (40-54), with different levels of education, income, access to insurance and mental health services, occupation, and support (presented in Table 1).

Each coder was encouraged to complete the coding process independently, alert to repeated parallel concepts to generate new ideas. The intention was to produce the most accurate results from the data collected. The researcher and the coders created a list of similarities and differences that they found in the data. The researcher selected the repeated elements of the data most pertinent to the research. At the last meeting, the

researcher informed the coders of the themes that had emerged, and the coders agreed that the themes were appropriate. Table 1 displays demographic information, including each participant's age, education, occupation, income, insurance, access to mental health services, religion/spirituality, and support system.

Table 1

Participant Demographics

Participant	*Age*	*Level of Education*	*Occupation*	*Income*	*Insurance*	*Access to MH*	*Religious/ Spiritual*	*Support*
Anisa	22	College	Fashion Buyer	$51,000-$100,000	Yes	Yes	Yes	Family Friends
Ashley	22	College	Unemployed	Less than $25,000	Yes	Yes	Yes	Family Friends
Shay	25	College	Unemployed	$26,000-$50,000	Yes	Yes	Yes	Family Friends Church
Tamara Saada	29	College	Behavioral Technician	$51,000-$100,000	Yes	Yes	Yes	Family Friends Community
Jane Doe	29	College	Educator	$51,000-$100,000	Yes	Yes	Yes	Family Friends
Lynn	33	Graduate Level	Project Manager	$101,000-$200,000	No	No	Yes	Family Friends Church Community Sports
Shanae	32	Graduate Level	Educator	$51,000-$100,000	Yes	Yes	Yes	Family Friends Church
Ameenah Banks	30	Graduate Level	School Social Worker	$51,000-$100,000	Yes	Yes	Yes	Family Friends
Kia	39	College	Nursing Assistant	$51,000-$100,000	Yes	Yes	Yes	Family Friends Church Community
Sharai	35	College	USPS Worker	$26,000-$50,000	Yes	Yes	Yes	Family Friends
Von	28	College	Logistics Manager	$51,000-$100,000	Yes	Yes	Yes	Family Friends Church
Imani	29	Graduate Level	Dept. of Defense	$26,000-$50,000	Yes	Yes	Yes	Family Friends
Tammy	31	College	Bus Operator	$51,000-$100,000	Yes	Yes	Yes	Family
Cognac	30	College	Bartender	$26,000-$50,000	No	No	Yes	Family Friends
Eva	29	Graduate Level	Unemployed	$51,000-$100,000	Yes	Yes	Yes	Family Friends
Lani	29	Graduate Level	Pharmacist	$51,000-$100,000	Yes	Yes	Yes	Family Friends
Kae'La	30	College	Medical Assistant	$26,000-$50,000	Yes	Yes	Yes	Family Friends Community
She	50	Graduate Level	Artistic Director	More than $200,000	No	No	Yes	Family Friends
Pamela	50	College	Behavioral Assistant	$51,000-$100,000	Yes	Yes	Yes	Family Friends Therapy
Delia	43	Graduate level	Assistant Division Chief	$101,000-$200,000	Yes	Yes	Yes	Family Friends

Ree	40	Graduate Level	LDTC	$101,000-$200,000	Yes	Yes	Yes	Family Friends
Vivian	41	Graduate Level	Educator	$51,000-$100,000	Yes	Yes	Yes	Family Friends
Native	51	Graduate Level	Social Worker	$51,000-$100,000	Yes	Yes	Yes	Family Friends Church Community
Kim	51	Graduate Level	Case Manager	$26,000-$50,000	Yes	Yes	Yes	Family Friends Church
Lux	51	Graduate Level	Teacher	$51,000-$100,000	Yes	Yes	No	Family Friends

Data Analysis

Grounded theory was the basis of this study's methodology. This theory allowed the researcher to begin the study without needing to test a hypothesis, but instead permitted the development of a hypothesis by observing (in this case listening to) the information participants offered (Auerbach & Silverstein, 2003). An important feature of grounded theory is that it uses the research participants as a source of knowledge, because they are considered the experts on the phenomena under investigation (Auerbach & Silverstein, 2003). It was specifically developed for building theory from data (Corbin & Strauss, 2008). At the beginning, analysis in grounded theory is often open and free, which leads to the development of concepts (Corbin & Strauss, 2008). Grounded theory gives the researcher the opportunity to develop these concepts by collecting information from interviews, observations, surveys, and focus groups.

Grounded theory methodology uses *theoretical coding,* a data analysis technique, to develop hypotheses based on responses from the participants (Auerbach & Silverstein, 2003). Coding entails identifying statements that are repeated or parallel, and determining the key idea, or theme, expressed by these statements. Themes are in turn related to

categories, perspectives associated with specific themes (Charmaz, 2006). This study utilized three types of coding: *open*, *axial*, and *selective*.

Coding gleans repeated ideas from the linguistic flow of the participants' responses to create analytic interpretations (Charmaz, 2006). The process of coding involves researchers combing and sorting the data in the initial phase of analysis (Charmaz, 2006). Coding requires six steps divided into three phases to construct a theoretical narrative from the raw data (Auerbach & Silverstein, 2003). Each phase conducts a different level of the analysis (Auerbach & Silverstein, 2003). The steps are not linear; therefore, the researcher could employ a recursive approach in completing the process (Auerbach & Silverstein, 2003). The first phase prepares the text for thematic analysis, deciding which data are relevant and choosing elements for the researcher to include in the analysis (Auerbach & Silverstein, 2003). The researcher's recursive approach required keeping the research concern and the theoretical framework in mind throughout the process. The research concern is the study's purpose, what the researcher wants to learn from the study and why. The theoretical framework will influence which data are included in the analysis (Auerbach & Silverstein, 2003).

In phase two of the coding process, the researcher focuses on ideas repeated in the data and develops themes from them (Auerbach & Silverstein, 2003). For an idea to be considered as repeated, it must be expressed by two or more participants in the study (Auerbach & Silverstein, 2003). The first filtering of repeated or parallel statements is performed by the researcher; subsequently, the coders conduct their own filtering process. The repeated ideas are assembled into larger groups that express a common topic, or theme (Auerbach & Silverstein, 2003). The third phase associates themes with

related perspectives, or categories, to build a narrative (Auerbach & Silverstein, 2003). When themes are developed, the categories will be understood on a deeper level as elements of a larger theoretical framework (Auerbach & Silverstein, 2003). The process ends by merging each step to create a narrative from the themes discovered in the participants' responses to the questionnaires (Auerbach &Silverstein, 2003). The themes serve to organize the subjective experiences of the participants and render them into a coherent, vivid story using the participants' own ideas and language (Auerbach & Silverstein, 2003).

CHAPTER 4: RESULTS

Emergent Themes

The findings of this study surfaced from the narratives derived from the transcribed semistructured interviews. Four themes with 10 categories emerged from the analysis of the data that were collected. The four themes developed from the data analysis were the perception of mental health and mental illness, the perception of seeking and providing help, the perception that mental health is unimportant, and the perception of violence by law enforcement and whites movement. Table 2 presents an overview of the findings, including the themes and the categories related to each theme. Direct quotes from the transcripts are cited to emphasize and define the findings.

Table 2

Themes, Categories

Theme 1: Perception of mental health and mental illness	Theme 2: Perception of seeking and providing help	Theme 3: Perception that mental health is unimportant	Theme 4: Perception of violence by law enforcement and whites
Category 1: Popular opinions of mental health	Category 3: More comfortable seeking help from people closest to them	Category 7: Mental health literacy is not taught in African American households	Category 10: Numbness and awareness (“Woke”)
Category 2: Popular opinions of mental illness	Category 4: Seeking help has been positive	Category 8: Negatives outweigh positives concerning mental illness	
	Category 5: Being kind to someone with mental illness is a standard behavior	Category 9: Help for physical health is perceived as more accessible	
	Category 6: Therapists are expensive		

Perception of mental health and mental illness. The first theme that emerged was a misconception of mental health and mental illness. This theme illustrates African American women's perceptions of what mental health and mental illness are. The concepts of mental health and mental illness are broad, complicated, multifaceted, and often confusing. Most professionals have learned an academic theoretical definition of the terms' meaning. This theme is the understanding of those who lack that theoretical definition.

Popular opinions of mental health. The women's responses centered on thoughts and state of mind; specifically, whether the thoughts are stable or unstable, positive or negative. Many of the women had a difficult time defining mental health without using the words "mental health." They were also concerned with what they believed were other components of mental health, such as trauma and coping skills. For example, She (50, graduate level, artistic director), stated that mental health "is your ability or lack thereof to cope with your emotions or mental health." Another participant, Kim (51, graduate level, case manager) described mental health as "a person's ability to cope with everyday stressors, well not stressors, but I would say… a person's, I guess, cognitive abilities to just deal with everyday life situations." There were some responses that revealed a degree of uncertainty. For example, Anisa (22, college, fashion buyer) described mental health as "something that people would, I guess, adjust mentality or the way you think. It can be positive, negative, just the way you think, I guess. I'm honestly not sure of the correct definition." Another participant tried to describe mental health using examples of mental illness:

> Not all people have mental health, but the ones that do have mental health, you know, characterized by schizophrenia, depression, and bipolar. So, I guess like people who are diagnosed with those things. I don't know how to answer the question, sorry. (Ameenah, 30, graduate level, school social worker)

Also, Lani (29, graduate level, pharmacist) stated:

> So I would describe mental health as patients and individuals who have some type of like, either like schizophrenia or depression or bipolar disorder. And I feel like for me, like what I see, like in the hospital is like mental health is kind of also something that's not addressed properly. So I feel like that would kind of be, like, a whole umbrella as well. Like a lot of people deal with mental health and different issues in different ways, but I feel as though it's something that's not really talked about.

It is important to note that both women specifically cited the same mental illnesses, not treatments, to define mental health. That could indicate common mental illnesses that are stigmatized in the African American community, as well as the negativity and misconceptions attached to the notion of mental health by some members of the community.

Forty-eight percent of the women were able to offer definitions of mental health as "wellbeing," "how healthy a person's mind is," and "balanced social, emotional, and psychological." It is evident that some of the women knew the fundamentals of mental health.

The differing views reflect the complexity of defining mental health. In the formal definition of mental health, the term encompasses several elements. These included

emotional, psychological, and social wellbeing that affects thoughts, emotions, and behaviors, as well as how to handle stress, relate to others, and make choices. The women's descriptions alluded to aspects of those elements but provided no full definition of mental health. This underscores the fact that mental health may not be understood in its entirety by African American women.

Popular opinions of mental illness. The second category, which emerged from the first theme, was uncertainty concerning mental illness. As with mental health, the women had difficulty defining mental illness in its entirety. Mental illness was defined in terms of specific diagnoses, deviation from societal norms, poor decision making, traumatic experiences, and levels of control. The women acknowledged that mental illness is the result of emotional and cognitive instability. For example, Kim (51, graduate level, case manager), defined mental illness as "okay, so mental illness is basically, you know, someone who has cognitive deficits that get in the way of their everyday functioning. And in their ability to, I guess, function well in society." Anisa (22, college, fashion buyer) observed that "a mental illness is something that you can't control." Another participant attributed the lack of control to a neurological deficit in the brain:

> I think mental illness can be a predisposed genetically or epigenetic to in the environment in itself, poverty, or certain things that you are vulnerable to. I think mental illness can be altered by traumatic experiences. I think mental illness can be substance abuse related, or it can occur just as organic. It just might be just something in your brain that makes you have that disorder. (Native, 51, graduate level, social worker)

Lux (51 graduate level, teacher) described the stigma that is attached to someone diagnosed with a mental illness:

> Most people tend to think that people with mental illness have to be crazy, and that's not true. You can suffer from stress. You can have some kind of traumatic experience as a child or as an adult, a death of a parent, a close person. You can experience, you know, something, a violent crime against yourself or another person. So, there are many things that people tend to have misconceptions of people with mental illness. And we understand that there are people who do have mental illness who can tend to make rash decisions and choices that could harm themselves or others.

Despite knowing the stigma and the negative views of mental illness, 24% of the women defined it as needing medication or seeking treatment. They conflated the illness and the treatment; moreover, this implies that mental illness is a manageable permanent condition without a definitive end. For example, Jane Doe (29, college, educator), described mental illness as "being misunderstood and misconstrued, sometimes some people think that having a mental illness is always a bad thing, where if with the proper treatment, a situation can be totally different with mental illness."

Perception of seeking and providing help. Many of the participants described occasions when they realized that they were experiencing stressful events that could be ameliorated with professional help. The women recalled various situations that required them to seek some form of help with managing their thoughts, feelings, and behaviors. Based on their responses, these experiences had always been positive for the women. They enumerated several approaches to seeking help. Sixty-eight percent of the women

sought help from family, significant others, friends, and the church. The forms of help described were prayer, reading the *Bible*, communication, journaling, yoga/meditation, and self-help books. The participants found it easiest to discuss stressors with the people closest to them. Although a few women sought help from mental health professionals, most did not benefit from it for various reasons. Many of the women were also able to be supportive when encountering someone who was struggling with a stressful situation or mental illness.

More comfortable seeking help from people closest to them. The women who endorsed this perspective felt secure in seeking help from those closest to them. They remarked that it was easier to communicate with trusted individuals. With the help of family, friends, or the church, they were able to manage the symptoms resulting from stressful experiences. As Krok (2008) found, the church and spirituality are a buffer during stressful events that help overcome difficulties. Religion has a significant influence on life satisfaction and happiness (Levin et al., 2005). Therefore, devout persons may have no need to seek help from a mental health professional, because their needs are met by their religion. Shay (25, college, unemployed) stated, “my mom is pretty supportive, and if she doesn’t really know the answer to something I’m going through, then she always walks by my side to help me through.” Von (28, college, logistics manager), reported that seeking help from the church was:

> Of course, a blessing, I can't say anything more than that, but a blessing. I think that the fact that I'm fortunate enough to have trusted people that are really good people, because sometimes we can be going through things that mentally challenge us.

Another participant described her church experience as rooted in profound trust:

> I definitely go to my closest friends. I know (when I was) younger when my parents were going through a divorce, I know my father had us go to like, ah, a pastor and that kind of was like our counsel in a way. So, I definitely lean on my faith with that sometimes when it's, like, really pressing where I know, like, my friends cannot handle the matter that I'm dealing with. So, my friends and my faith. (Imani, 29, graduate level, Dept. of Defense)

Native (51, graduate level, social worker) described her method of seeking help through self-help:

> Well, believe it or not, I always been in some self-help process. I'm currently doing Iyanla Vanzant, a monthly spiritual spa. I'm a follower, more or less. Every month we do a spiritual spa, virtually. We have homework. I actually have a twenty-seven-day immersion worksheet that I do daily, which is more of a growth development. It's not so much healing. And I also do workshops.

Seeking help has been positive. As stated, the women reported positive experiences when receiving help from various sources. Twenty-eight percent of the women described having a positive experience when they sought help from a professional. In general, the women's responses indicated that they found comfort in having someone to talk to about their concerns. It allowed them to take that Superwoman's "cape" off, to be vulnerable and receptive to the help. Lani (29, graduate level, pharmacist) described her experience of receiving help from a counselor as a "breakthrough." Another participant, Ashley (22, college, unemployed) stated:

> So, I have a counselor. Well, I got the counselor through EOF (Educational Opportunity Foundation), but she helped me whenever I was going through something. I think like we just talked about, like home life and stuff that goes on in the house, and I know it's kind of easy to open up, because I felt like she actually genuinely cared. I think that everyone should have someone to talk to.

She (50, graduate level, artistic director) discussed her life-changing experience:

> So, I felt like it was rewarding having someone that you can be totally honest and transparent with that didn't care, like, you knew it was their job not to tell your business. That was a release. Another time when I've gotten counseling, it was rewarding, because they helped me find out who I am, no, they helped to change my life, meaning they taught me stability is in me, my daughter's stability is in me, it's in the place. And that was rewarding, totally rewarding for me. Total life changer.

Being kind to someone with mental illness is standard behavior. Although the participants found seeking help to be a positive experience, they also described positive experiences when giving help. Along with helping friends and family, some women related that they had at least one encounter with a stranger with suspected mental illness. The consensus was that people should be “empathetic”, “kind”, and “positive” when helping someone going through a stressful experience or diagnosed with mental illness. This is analogous to the idea that Abrams et al. (2014) referenced concerning African American women typically assuming nurturing roles and being supportive of others. It also made the women view mental health and illness emotionally, using words like “sad,” “hurt,” and “heartbroken" to characterize how helping someone made them feel. Shay

(25, college, unemployed) was not sure if she had ever had an encounter with someone struggling with mental health, but if she did, she reported "I would try to be as supportive as I could." Tammy (31, college, bus operator), who had worked with mentally ill persons for several years stated, "I worked in the field for about seven years with mentally challenged consumers...it gives you a better light on people." Ree (40, graduate level, learning disabilities teacher consultant) expressed that "I was supportive and glad that that person was able to seek help." Another participant described her experience as:

> . . . making sure I react, giving him the help that he needs, but not overreacting. So as much as I might be shocked or surprised, like, oh my God, he's my brother experiencing this and making sure like I'm being present for him… I also find (in) my experience when it's normalized, where you're not overreacting or acting weird, they come back to you and talk to you. They're more likely to come back. So, they can really talk to you about what's going on. And that way you're better able to help them out. (Eva, 29, graduate level, unemployed)

Therapists are strangers and expensive. When explaining their comfort with people closest to them, the theme of therapists being strangers and expensive emerged. Several of the women expressed their thoughts on communicating with a "stranger" and their views were mixed, both positive and negative. For some it would be an easy task to open up to a therapist, but others found it difficult. Historical mistreatment has caused the African American community to have a general mistrust of the medical field. That mistrust could contribute to a cultural reluctance to broadcast information about themselves to others in order to remain private and not feel guilty about certain things in their past. For example, Anisa (22, college, fashion buyer), observed "they're a complete

stranger. So, it's like harder to open up to somebody that you don't know." Lynn (33, graduate level, project manager) responded in a similar fashion:

> It will be hard for me to, like, spill all of this stuff to this person knowing that, like, this person could never be, like, a person in my life. That's like a real relationship. They're always going to be like, a doctor… to me. And I think that that's hard for me, because I don't really love surface level relationships. So here I am, like spilling my whole life to someone who I know nothing about.

Conversely, "stranger" was described in a positive way by Lux (51, graduate level, teacher):

> It was a positive experience because it allowed me to open up to a stranger who wasn't involved in my relationship. So, it was a neutral ear that allowed me to express how I felt. And you know, the person gave me strategies for coping.

Ashley (22, college, unemployed) endorsed the same sentiments:

> . . .I think the best person to tell it to is a stranger, so that they can give you a look that people that's around you won't give you. Because you can go if you could talk to, like, a family member… But they have already been there. They might see it a different way than a stranger will see it, because they can't take themselves out of the context and on a personal level.

Regarding the expense of a therapist, 36% of the women cited cost as a major barrier to seeking a mental health professional's help. The thought of "paying out of pocket" because of the lack of insurance coverage or high insurance copays was unacceptable. Cognac (30, college, bartender) stated that the reason she does not seek therapy is "because I don't have any money. That would be the reason. These therapists

are expensive." Another participant, Jane Doe, 29, college, educator), likewise stated that she "refuse(s) to pay out of pocket."

Other reasons the participants cited for not seeking help from a therapist were a lack of access to therapy in their community, appointment/scheduling difficulties, and fear of an incompetent therapist, in the senses of knowing effective techniques and of working with African Americans. Culturally adapted treatments and interventions have demonstrated their effectiveness in treating African Americans, especially in reducing symptoms of mental illness (Ward & Brown, 2015). Nevertheless, disparities in the quality of care persist (Noonan et al., 2016), especially in poorer communities that lack adequate access to health and social services (Mays et al., 2007). Ashley (22, college, unemployed) noted that where she lives, no mental health resources were available, and none became available until she went to college. Another participant, Eva (29, graduate level, unemployed), emphasized that she sought therapy from a mental health professional, but "it was very hard to find someone who was available." When she did find a therapist, she remarked,

> I felt like I was on the defensive trying to feel, like, trying to express my experience to her and feeling, like, I was being believed, so that that was a struggle. And I don't know if it was something with the race or ethnicity or the dynamics that (were) going on in the room.

The perception that mental health is unimportant. Many things that parents teach are considered important. The theme of mental health care being unimportant emerged from the participants reporting that they did not learn about mental health in their household or from their parents. When expressing their thoughts about mental

illness, the women had more negative remarks than positive. That was also reflected in their definitions of mental health and mental illness. Judging from these participants' statements, mental health only becomes important if it relates to physical health, and if it can be addressed by a primary care doctor.

Mental health literacy is not taught in the African American household. All participants reported that they did not learn about mental health or mental illness from their parents. Most learned from an educational setting, work, social media, or television. Although it was not taught, some of the women stated that they were exposed to a family member with mental health-related concerns as a child but did not understand what it was until they became adults. This realization led to some of the women conducting their own research into mental health. For example, Anisa (22, college, fashion buyer), remarked "honestly, I heard about mental health illness from, like, going to school, like, not really much at home because, you know, that's not something you just bring up." Similarly, Native (51, graduate level, social worker) learned about mental health and mental illness from school:

> Oh, I would say being in school, you know, going to college, getting my master's in social work, I did learn about, you know, some, of course, psychotherapy and, you know, mental illness. You know, I took a couple of classes on behavioral therapy and things of that nature, so I would say school definitely.

For another participant, conducting her own research was beneficial as an educator: "I did my own research. I've been in education for about 10 years now. About two years ago, we had this bright idea to have students in a group talk about their experience living in Baltimore city" (Shanae, 32, graduate level, educator). For this participant, learning from

her own research afforded her the opportunity to provide that information to her students. This echoes the notion that mental health literacy is learned in school.

While discussing mental health literacy not being discussed in the household, a few participants recalled a silence being imposed in early childhood. Adults in the family instructed them not to communicate with certain family members who had "problems." Years later, the participants learned that the problem was related to mental illness. One participant mentioned that,

> . . . I was eight years old, and at the time, I wasn't really aware of what mental illness was, this was like the mid-seventies and as time went on, I noticed some odd behaviors with her. And once I went to college, I started understanding in retrospect exactly what was going on with her. (Lux 51, graduate level, teacher)

Another participant related a similar experience with her uncle:

> In my early life, it was it was almost 100 % negative and just now being exposed to it, but not really told how to handle it, there were certain situations where, again, with my uncle, he would stay with us. He never did anything harmful to us. But it was just more of the things that he said, you know, in the ways they do things and not, you know, there were points where we thought it was funny as children what he said, but looking back, it was, like, not to say that we should have been around him, but we should have been taught how to deal with those situations. And then, when I went to college, I double majored in psychology, so I had exposure then. (Vivian, 41, graduate level, educator)

Negatives outweigh the positives in terms of mental illness. All of the women offered insights about mental illness, and more were negative than positive. Based on the

responses from the women, the negative messages were easier to recall. Those negative messages elicited the stigma attached to mental illness, how it was a taboo topic for discussion in the home. The only positive message that the women offered was that they knew help was more available now if needed, making mental illness more manageable. Imani (29, graduate level, Dept. of Defense), explained how she interpreted the message that she received:

> Yeah, sure. So, I know when we first started mental health in the African American community, so that's definitely kind of like the elephant in the room kind of concept. You don't really hear about it. Don't really talk about it ... Pretty much not at all. That's definitely the negative side of it.

Another participant had received a similar message but also indicated that there are limited positives, but more than there were years ago:

> Well, negatives (are) going to be easier than … the positives because I feel like more so now you hear more of the positive than like maybe a few years back. So, negatives I always hear about mental illnesses are like people are crazy. They going out of (their) mind, they losing (their) mind. Stuff like that, I will say I'm trying to think of other negatives. Um. Mostly, I would say those things like because if you see somebody, oh something happen(s) to somebody on (the) news, they running around with no clothes on or something like that, and then (they're) all crazy. They've got something going on. (Kae'La, 30, college, medical assistant)

Anisa (22, college, fashion buyer) had difficulty finding the positives:

> I can't think of many positives, but I will say that, you know, like I guess a positive in a way is that the person can't control it. So, it's not as if they want to do it is just like in their mind. But that's not really much of a positive, a lot of negative things I've heard, of course, is that you know, the person is just, like, I mean, I'm only associating mental illness because like I said, the first thing I think of is, like, the school shooting.

In contrast, the positive message that emerged several times among the women shows that there is currently more positive awareness of mental health and mental illness. The women mentioned medication and therapy or programs that are available to help. Tamara Saada (29, college, behavior technician) mentioned, “a positive message would be that it could be helped that there are different programs that people with mental illnesses can get help. That's a positive message for me”. Another participant, Pamela (50, college, behavioral assistant), stated:

> That there the positive (are) that there is help, that you are not the only one to go through, it is so many other people that are going through this. So don't think that you're alone. There's websites, there's people you can talk to.

Although there are several negative messages, those are messages that were taught years ago. As the women mentioned, more positive messages are emerging recently.

Help for physical health is perceived to be more accessible. The theme that physical health care is more accessible was stated by many of the women who were having an easier time caring for their physical health. Many of the women used their primary care physician to “one-stop shop” and at those appointments, they seek help with mental health-related concerns in the hope that they will receive it. It is also important to

note that the women referred to immediacy when discussing physical health issues. They believed that addressing physical health concerns is more urgent. It's also easier to seek help for physical ailments because primary care physicians are available in the community, and no stigma is attached to seeking help for physical complaints. Cognac (30, college, bartender) reported:

> I will say, because, you know, you use your body every day, even though you do use your mind every day, you know, I don't think that. I wouldn't realize something with my mind… until I'm like in the midst of everything that I'm going through or feeling some type of way. Versus, I guess, my body is aching, you know, it's like an immediate thing. And you use your body, you realize you use your body more.

Another participant had a similar thought but also raised the difference between the degrees of effort it takes to care for physical and mental issues:

> So, from our physical health, I mean, I feel like it's something you can fix it with a Band-Aid, such as medication for a headache, knee hurt, or something like that. But sometimes with mental health, you need to talk things out. That medication you can't buy over the counter, and sometimes you can't let things bottle up because that makes it worse. So, talking to people who can assist you through it and help you, it is different than being (treated) with the over-the-counter medications. (Sharai, 35, college, USPS worker)

Anisa (22, college, fashion buyer) acknowledged that difference as well, and how much easier it is to go to the "typical" doctors:

> I feel like with mental health, a lot of people are more sensitive to it, since it's like, you know, like everyone goes to the doctor, everyone goes to the gyno, everyone goes to, you know, that's just like normal things that people do. But I feel like when it comes to mental health, people are more hesitant. Me specifically, I feel like the difference is, I wouldn't think, like most people don't think, to go to a professional for mental health, they think they could just, like, handle it themselves. Like I said, just talk to friends or family to help with it. So, I feel like the difference would be, I wouldn't take it as seriously as I would, like, if I was to be like you say, like, sick. I would go to my doctor immediately.

She (50, graduate level, artistic director) felt that there was no difference between physical and mental health help-seeking:

> I think African American women, I think we wait until it's always broken down to the end to go get it. I think physically and mentally we wait until there's nothing; You've done everything else; you've tried to self-medicate; you've tried on both ends. And then when it's so out of our control… to me most times it's too late and we go get it.

Perception of violence by law enforcement and whites. The Black Lives Matter (BLM) movement is a new version of an African American empowerment group. The BLM may also be considered as a collective community-level mental health treatment for African Americans. This movement has offered African Americans a forum to discuss what is happening and how to cope with the violent oppression that they have suffered for centuries.

Numbness and awareness (Woke). For the women in this study, the BLM and the historical legacy of oppressive violence by whites evoked two distinct reactions: numbness and awareness (being *woke).* With all that has happened related to the BLM, many women felt desensitized and lacked emotion. Others recalled how this impact has awakened instincts to do more for their community. For example, Jane Doe (29, college, educator), resonated with the notion of lacking emotion, stating, "like, I hate to say this, but, like, I block out my emotions. I'm bothered by it, but I don't show it, it's hard to explain. Like, I'm saddened, but I won't lose sleep. If that makes it." Another participant shared these same sentiments, reporting:

> Honestly, no. The whole Black Lives Matter movement for me is...And I don't mean to sound like this. I'm going to put everything together, right, the Black Lives Matter movement, the covid that happened last year, the presidential election, all these different things that have been happening, unemployment rate, all of these things that have been happening in the past year and a half have not affected me in the way that it has other people. And I say that because, like, I live my own life, right, and I operate my own life, and I don't believe right now where my life is. Yeah, OK, when my brother walks out of this house, am I worried about him or my dad or whatever. But I'm not somebody who that … when something is going on in the world, that I have to literally let it affect every single conversation that I wake up and have. Because I'm sorry, at the end of the day, like, I can't speak about those things at work because of the type of job that I have. I'm not going to call my mom. And every single time I talk to my mom, talk about the African American boy getting shot, like, yeah, we'll talk about it on

> Monday, but then the next Monday, I'm not going to keep talking about the same things. Like, we know what's going on in the world. And I think that we're all aware, and I think that we all have our opinions. But then there's some people that literally let it take over their lives. And then there's some people like me that acknowledge it. And we know that it's there. (Von, 28, college, logistics worker)

Another participant expressed some of the reactions and became emotional during the interview, needing a moment to compose herself:

> I haven't really thought about like seeking any help for that honestly. I feel like in some instances I'm just, like, numb to it. Which I know isn't good, but I don't know, I just, I never thought about using it as an outlet. I just feel like I just go through my emotions, talk about it. Try to get through the next day, with hopefully not seeing or hearing about something, but that at this point seems like that's impossible. I mean, now that you asked the question, I feel, like, it might not be a bad idea to talk about it. And because. No, I mean, I notice it, but it's like moments like this where I feel, like, it really hits you. When you have time to actually sit down and think about it, like, I'm a very busy (person) for the most part. So, I don't. I've been trying to, like, take more time for myself, so, I mean now that you brought it up, I feel, like, maybe that's something I should address or talk about because I go through the emotions when stuff is going on or even sometimes, I try to just block it out. Uh, so, I feel like now I probably will be definitely more willing to do it, because I can have conversations with my family and my friends. But maybe I need to have a different conversation with a therapist to tap into these moments of like this deep emotion. Because I don't know that it

> affects me in the way that it has been, I guess. So, I guess I would say I'll be more willing now with the unfortunate events. (I'm) not saying that I wasn't willing before, but like right now I'm, like, emotional about it so much that it's, like… damn I didn't even realize that it got me to this point. (Kae'La, 30, college, medical assistant)

Other women had opposite responses, wanting to do more for the community, to see justice prevail in certain situations. Anisa (22, college, fashion buyer) said,

> It has impacted the way I've thought about things and how I want to do more for my people. I feel like it's done more, like, me wanting to be more like the activist, even though I haven't done anything like…go to any protest or anything. But I'm just saying, like, it's definitely made me… like, I mean, I already was for my people, for myself, or for all of those. But now I'm even, like, I have a much stronger opinion of those things. And it just, it definitely has broadened, like, opened my eyes to how people of other races are. Not trying to, like, say that I'm against certain people, but definitely I am more aware of how certain people act like you know, based on, like, the elections and like you said, the Black Lives Matter movement. So, I necessarily don't feel like I needed treatment for that. But it definitely was a hard experience to, I mean, a hard thing to have seen experienced through social media, because those are my people.

Another participant had the same sentiments regarding having more awareness:

> . . .So, I think that's, that's what happened with Black Lives Matter for me is just recognizing the plight and that it's hard out here. And people were treated so

> poorly and it's so hurtful, so bad. And everyone just, you know, having a hard time. But for me personally, it's just that awareness. (Delia, 43 graduate level, assistant division chief)

Some participants reported that BLM and the recent violence against African Americans had made them think about how someone close to them could have been a victim, and ways that they could protect family members, especially the boys and men in their families. Sharai (35, college, USPS worker) focused on her son in particular:

> I did say that I would like to get my son therapy for it, because he is a young African American man growing up to be an African American adult, and I just want him to be prepared and, you know, ready for when things like this may happen to him or people (of the) same skin color may experience these things. I don't feel like this ever will go away. So, I just want him to have the tools to be able to handle this, and even now he may feel some…way about it, but he's only 12, so he doesn't really express. He will say that's messed up that they put that knee on his neck or things like that. But he hasn't shown me any concern that, you know… He's scared for his life that it will be him, (and) it can possibly be.

Kia's (39, college, nursing assistant) view resonated with Sharai's, mentioning her children and in particular her older son:

> . . .Because when you hear about that, I have five boys and one girl. So that you just struck a little, you know, sympathy, because nobody wants to go through that. So, and for us, every time, even for my son who is twenty-two years old. They have their own cars, they drive. And every time they go out or every time I do stuff, I'm telling them, listen, just obey a cop, and you got to have that

> conversation with them. You know, even if a cop pull(s) you over, what you're going to do, and sometimes you do get paranoid about it. But I have to tell myself and try to control myself, like, it's happened all over the world. But at the same time, you don't want it to happen at home.

Another idea reiterated in the women's responses concerned the linkage of the BLM's profile among African Americans to the killing of a specific person that prompted a BLM protest. They offered names of several African Americans who had been killed, like Breonna Taylor, George Floyd, and Trayvon Martin. Those responses evoked some deeper emotions for some of the women, because they had not realized how long the list of names had grown and acknowledged that it will continue to grow. That stark realization elicited a conversation about police brutality in America and the degrading treatment that African Americans must endure living in America. Imani (29, graduate level, Dept. of Defense) shared:

> The 2020/2021 Black Lives Matter movement, it's no surprise to me anymore …I was a freshman in college when Trayvon Martin was murdered, and that was my first take on out there with, like, the African American Student Alliance group (and) campus marching, protesting, all of that. And that was over, give or take, eight years ago now, and since then, there has been many African Americans killed through police brutality and so forth. And to answer your question, I think for me, it caused me to kind of really check in with my mental (awareness) to really understand how I (could) react in a more effective manner, (I'm) not saying that protests aren't effective. It's just how can I utilize my networks that I'm a part

> of (now), as I've gotten a little bit older post-college, to really make that positive difference or at least bring that awareness to the social injustice.

Another participant referred to the more recent case of George Floyd:

> So, when it first started, I was calling my counselor a lot to talk about the events that were happening, and I was really upset and then felt, like, even when I would start to find out more stuff that might have been undercover. So, I would say it kind of affected me a lot. But after a while, I just, you know, you just learn to deal with stuff, like, not learn to deal with it like it's okay. Just start to expect it, like even with the case going on now and stuff. Now, like the George Floyd, like, I haven't looked at anything. I saw some videos and I'm like, I can't watch it. (Ashley, 22, college, unemployed)

Ameenah's response (30, graduate level, school social worker) focused on how it becomes difficult to see one murder after another and be unable to heal, because there are too many:

> . . .America, for instance, you know, everything is televised now. I just hope and pray that more people are open to getting therapy. I pray that, you know, everything that this is doing to other people, that they are open to get help, you know, like to just process their thoughts and just everything, like, you know, waking up and seeing a million African American people getting killed at a high rate. You know, every time we turn around, it's Floyd, it's Breonna. You know, it's just a lot.

CHAPTER 5: DISCUSSION

Interpretations and Implications

The purpose of this qualitative study is twofold: to better understand African American women's attitudes and perceptions about obtaining professional mental health services, and to contribute to the literature devoted to expanding that understanding. This study examined the perspectives that African American women have on mental illness and seeking help from mental health professionals through the grounded theory of analysis. In particular, the researcher sought to identify and conceptualize the barriers that African American women face in seeking professional mental healthcare, and to determine if attitudes and perspectives concerning professional mental health care may have changed generationally. Historical events such as the Henrietta Lacks saga and the Tuskegee Syphilis Experiment and the lack of cultural competence among medical professionals may make building therapeutic relationships with African American women challenging. In this study, four themes emerged, *Perception of mental health and mental illness, Perception of seeking and providing help, Perception that mental health is unimportant*, and *Perception of violence by law enforcement and whites*. These themes further illuminated the reasons why African American women don't seek help from mental health professionals because of barriers like the Strong Black Woman schema, mistrust in medical professionals, and lack of accessible services.

As Morris (2016, 2019) pointed out in her article and book, *Pushout: The Criminalization of African American Girls in Schools and Countering the Adultification of African American Girls*, many African American women have learned from an early age that they were viewed as adults by teachers and school personnel. As children, they

were treated as if they were older than their years and often given harsher punishments than their white counterparts. The perception of maturity and strength in African American girls that increases the severity of punishments inflicted upon them is a bitter irony, because at home these girls learn the imperative to be strong, not weak, because weakness means that you will be punished.

The idea of weakness causes fear for African American women. From a young age, African American girls are viewed as adults not needing a lot of support and left to figure things out on their own. They are not coddled or handheld like some of their white counterparts. Seventy-two percent of the women in this study validated the perspective that African American girls and women who handled their problems and stressors independently were less likely to seek help from a professional, instead relying on themselves or those with whom they have close relationships. This perspective was exemplified by Lani's response (29, Graduate level, pharmacist), "I just felt like the times when I was super stressed out with school and work and everything like that, I would have rather dealt with it with myself and talk to my friends." Of that 72% who shared this view, their ages ranged from 22 to 51, indicating that there was no generational difference in the perception that help is most likely to be obtained from their own resources.

African American girls and women face a myriad of stressors, not only routine life stressors but others that derive from gendered racism, inadequate and insensitive health care, and an array of psychological stressors (Perry et al., 2013). African American women have the highest rates of wage inequality in the workforce (Morris, 2016), the highest rates of inequality of health benefits (Morris, 2016), and they experience mental

health disorders, such as severe depression and anxiety (Hudson et al., 2016; Waite & Killian, 2008; William & Lewis, 2019). Allen et al. (2010) asserted that African American women are taught to cope without seeking professional mental health care and instead tend to rely on clergymen, church, prayer, and altar calls. Kia (39, college, nursing assistant) declared that she is a "prayer warrior." Kim (51, graduate level, case manager) stated "talking to my pastor, you know, having that spiritual base, that also helped me." And lastly, Cognac (30, college, bartender) reported that, "I would read the *Bible*, honestly, like pray."

A striking finding in the participants' perception of mental health and mental illness is that although most of the women were able to offer a general understanding of mental health and mental illness, two respondents, Ameenah (30, graduate level, school social worker) and Lani (29, graduate level, pharmacist) both used terms like "schizophrenia, depression, and bipolar" to define mental health. This suggested that African American women would benefit more from education in *mental health literacy* (MHL). MHL consists of knowledge and beliefs about mental disorders that aids a person's recognition, prevention, and management of mental disorders (Jorm et al., 2006). Most of the women in this study were able to express a general understanding of the terms mental health and mental illness, yet some were unable to differentiate the two terms. Sixty-eight percent of the women reported that they were formally introduced to the concept of mental health in high school or college, at work, from the media, or through their own research. For example, Shay (25, college, unemployed) stated, "I would say when I was in college, my psychology class was like, well, yeah, I would say

it was the first time I ever learned about mental health and mental illnesses." Tamara Saada (29, college, behavioral technician) reported,

I was never really taught it, I guess I just came in contact with individuals that thought negatively and, like, reading about it. I don't think I ever even read anything really on mental health. It was just I guess I could say social media and, like, media period. Them portraying what mental health is and isn't.

The concepts of mental health and mental illness were taught subliminally in the African American household in a way that focused on the stigma of mental illness as the negation of what it means to be strong. The data from this study related to the theme *Perception of seeking and providing help* indicate that some African American women view seeking help within themselves or from someone who is close to them, such as their family, friends, or church, as safe and beneficial methods of coping with mental distress. The women found it easier to discuss their problems with those who understood their experiences. Oftentimes, African American women do not feel safe in mental health treatment offices, a mistrust rooted in historical abuses by the white medical establishment, as well as by the lack of access to culturally competent professionals.

It is noteworthy that some participants in the study had sought help outside their communities and contacted professionals with formal training in the field of mental health. Women in the study who had received professional mental health services stated that their experiences were positive, and they believed that talking with someone was helpful. The women who found professional treatment helpful also observed that they were hoping to gain a perspective different than their own from their therapists about a

problem. By seeking help, these women displayed courage and disproved the stigma of weakness. For example, Lux (51, graduate level, teacher) stated: “It was a positive experience because it allowed me to open up to a stranger who wasn't involved in my relationship. So, it was a neutral ear that allowed me to express how I felt. And, you know, the person gave me strategies for coping.” Ashley (22, college, unemployed) recalled, “So, the first time I went …my first summer in college, I think like we just talked about, like home life and stuff that goes on in the house, and I know it's kind of easy to open up, because I felt like she actually genuinely cared.

Issues with accessibility were presented by other women in this study, who reported they tried to seek help from a professional but ran into difficulties with insurance, available appointments, and lack of a therapeutic alliance. Along with struggling to find a therapist who had appointments available, it was also hard to find someone who looked like them, indicating that cultural identification with the therapist may make the therapeutic process easier. Moreover, access to an ethically appropriate therapist was rare for African American people compared to the quality of care that white people experience (Noonan et al., 2016). Due to these disparities, African American people tend either not to receive professional care or to receive poor quality of care (APA, 2017). For example, Pamela (50, college, behavioral assistant), reported that she,

> … Reached out to the insurance company, some of the facilities didn't have room, like, they didn't have appointments available. Like for months. And I reached out to a friend of mine, (who) directed me to a therapist that she knew would possibly be able to squeeze me in to her schedule. But I didn't feel like it was beneficial once I started seeing her.

Jane Doe (29, college, educator) shared a similar experience when it came insurance and the cost:

> So, on Google, when I look, they don't take my insurance, so I will have to pay out of pocket. Yeah. So, I would have to pay out of pocket, whereas with my insurance company going through them is like going through loops. So I go, it was, it seemed, like it's never an easy way.

For the women who had tried to find a therapist, lack of access made it difficult and discouraging. Even when therapists are available, they sometimes lack the therapeutic skills and cultural competence needed when working with African Americans. Therapy is supposed to be a safe space for patients, and that is not always the case for African American. For example, Eva (29, graduate-level, unemployed) stated:

> So, it's also finding someone that you connect to… feeling like your story is being heard. So, when I actually did go through my first intake session, this was the first time I actually decided to go see a therapist, and the whole time and then questioning if she's actually understanding what I'm saying, or if she's, like, questioning me. If I'm lying about, if I'm being evasive about certain information, so I felt like I was on the defensive… trying to express my experience to her and feeling like I was being believed, so that was a struggle. And I don't know if it was something with the race or ethnicity or the dynamics that w(ere) going on in the room.

In accordance with the findings for the theme, *Perception that mental health is unimportant*, African American women have historically learned to be self-sufficient in caring for themselves and others, leading to the assumption that asking for help is a

weakness, and one must strive to exhibit extraordinary strength, self-reliance, and uncomplaining silence when faced with hardships and stress (Watson & Hunter, 2015). Many African American women become strong physically, mentally, and emotionally because of the arduous circumstances they constantly face. The Strong Black Woman Schema was exemplified in Sharai's (35, college, USPS worker) statement, "… I knew that I (would) overcome it. It wasn't nothing that I thought I was going to harm myself or anyone else to get rid of this overwhelming stress feeling." According to Ward and Heidrich (2009), when mental health services were utilized by African American women and men, they were more likely to have negative experiences and less likely to return to mental health facilities, even if their illness persisted.

The data concerning the theme, *Perception of violence by law enforcement and whites,* suggest that the women in this study may have been emotionally overloaded or emotionally shut down. Conducting the research in 2020-2021, during a simultaneous national racial crisis and global pandemic, African Americans were disproportionately affected by COVID-19, as well as murdered at the hands of law enforcement and white people. The women interviewed for this study expressed many emotions regarding the violent racial events and the pandemic. Some of the women reported feeling either numbness or intense awareness, a hyperfocused state. Those emotions could potentially cause more stress for the women. Some of the women, however, indicated that they had not thought much about how these recent events had impacted their mental health. Kae'La (30, college, medical assistant) found it hard to hold back tears as she stated,

> … "Yeah. It's like we just so disposable… it's like so normalized, it like this is okay. Like, I feel like the younger generations are going to see this like. Okay,

> like that happen, all right. Another one, and there's not going to phase them as much because it's happening so frequently when I feel like for me and maybe like my generation and older and, like, it's a little different. Because I would have never thought that I would be witnessing this so much in the limelight. You know, I thought that was like something of the past, not saying that it was completely gone because I don't believe that, but I wouldn't have thought in a million years that I would be seeing all these hashtags of grown people to babies. So. It's just a very emotional thing that I think is just like I said, you just get numb to it and it's just like. Damn, you don't realize it until you in your own space, and it's like silence and, questions like this, this is…like shoot, damn, like it gets the wheels turning and start and get you to start thinking about it.

Kae'La's comment about different generations imparts a sense of history repeating endlessly with the wrongful killings of African American people by law enforcement and white people. So, not only do these emotions and reactions stem from historical events like the Tuskegee Syphilis Study and Henrietta Lacks but the continuation of that maltreatment. The impact of these events has led many African Americans to mistrust those who are "supposed" to help, e.g., police, doctors, and others in the "helping" professions. In thinking and talking about things that were stressful, some of the women realized that they had been profoundly affected by the racial violence and the global pandemic; other participants unwittingly expressed the emotional impact. Perhaps being strong may mean denying what you feel in order to survive. Over time, however, showing strength and not seeking appropriate support, because it may be considered unimportant or suspect, can be detrimental to mental health.

In the wake of the deaths of Breonna Taylor and George Floyd and the contemporaneous COVID 19 pandemic, the Black Lives Matter (BLM) movement had more impact than in previous years. The BLM movement was founded in 2013 by three women following the acquittal of the accused killer of Trayvon Martin (Green et al., 2021). The movement was created as a means to promote liberation from oppression and to make the voice of the African American community heard through combating racism (Green et al., 2021). Creating a safe space to discuss the trauma with others has been important for the African American community. African Americans have endured social injustice for far too long, and the BLM movement serves as a community level of treatment when individual therapy from a professional may not offer hope.

Theoretical Models that Support Findings

The findings of this study indicate that the participants were able to discuss their understanding of mental health and how they acquired it. The data highlighted their ability to acknowledge their developmental and cultural perspectives on mental health professionals in order to help them understand their help-seeking behaviors. Aspects of Intersectionality, *Social Learning Theory*, *Social Constructivism Theory*, and *Cognitive models* validate this study's findings. These theories can be used to incorporate African American women' experiences and perspectives in developing interventions.

Social Learning Theory

According to Social Learning Theory, a new pattern of behavior is learned through direct experience or by observing the behaviors of others (Bandura, 1971). The results of this study illustrate that these women have observed much of what it means to be an African American woman in America, and what they learned may have affected

their perception of seeking and receiving help. Strength has been a defining value for African American women dating back to slavery. Research has demonstrated that African American women have inculcated strength as both a virtue and as a role to enact. African American women exhibit strength in caretaking or helping others, in achieving success despite restricted resources, in resisting vulnerability and emotion, and in making independence a priority (Abrams et al., 2014; Beauboeuf-Lafontant 2007).

The method of learning through observation appeared in the data. The women's responses indicated that they were more receptive to helping others with emotional needs or recommending therapy than seeking professional help for themselves. As children, the women directly observed how mental health was handled: the absence of factual education about mental health in the home, or being told to avoid someone who may have been struggling with their mental health. For example, Vivian remembered being told not to be too emotional, because it could lead to a mental illness. The participants also observed people suffering from mental illness and from the stigma it brought. African Americans developed a belief that mental health is something negative that should not be discussed. This misconception has been transmitted from generation to generation, which is borne out in the data by the similar experiences and perspectives found in the different generations of women in the study.

Social Constructivism Theory

Complementing Social Learning Theory, Social Constructivism is an active mode of learning through interactions and discussions with others (Davis et al., 2017). This approach emphasizes how people understand and construct their world and experiences through social interactions (Creswell & Poth, 2018; Nelson et al., 2020). Social

Constructivism recognizes that sociocultural context shapes African American women's perceptions and beliefs related to seeking help from mental health professionals (Nelson et al., 2020). It requires an attempt to understand the women's worldview by listening attentively to their self-expression and making sense of their life events (Nelson et al., 2020; Ponterotto, 2010). In addition, the Social Constructivist approach proposes that meaning and understanding developed socially and experientially are therefore constructed intersubjectively (Mertens, 2009; Nelson et al, 2020).

The results of this study indicate that the participants learned the negative associations of mental illness partly through the silence about the topic the household, which lent support to the notion of coping with mental health problems on their own and that seeking help from a professional revealed weakness. The women fond more comfort in the methods that had been passed down for generations, like talking to confidants or trying to manage on their own. They have become dependent on those inherited but flawed methods. For example, Sharai remarked, "I didn't think I was going to harm myself or anyone to get over (feeling so overwhelmed)."

Cognitive Model

The cognitive model emphasizes that thoughts and beliefs are significant in the development of emotions and behaviors (Beck, 1964). Thoughts and feelings, emotions and behaviors are interconnected. The model focuses on a process in which different situations elicit thoughts that determine how those situations are perceived. Beck, Rush, Shaw, and Emery (1979) proposed that maladaptive beliefs and thoughts are likely to result in psychological distress. If a situation is perceived in a negative light, it may lead to negative behavior. When negative thoughts are replaced with positive, adaptive

thoughts, the outcome is likely to be positive behaviors. This process is known as cognitive restructuring, which identifies and replaces reflexive negative thoughts that may lead to negative emotions and behaviors (Beck, 1995).

The findings of this study indicate that all the women harbored some negative thoughts and beliefs about mental health and seeking help from professionals. The fact that some of the women viewed therapists as strangers in a negative context may inhibit them from seeking mental health care. For example, Anisa observed, “they're a complete stranger. So, it's like, harder to open to somebody that you don't know.” Even if Anisa were to seek help, she may not be as forthcoming because of her perception of therapists.

Intersectionality

Intersectionality, a term coined by Kimberlé Crenshaw (1989), is the interaction between systems of oppression related to race and sex, and the resulting relationship can shape social and political life (Weldon, 2008). African American feminists have argued that their problems differ from those of African American men or white women (Weldon, 2008). African American women face many problems that arise from who they are, with their unique identities, perspectives, and experiences. When examining intersectionality, race and gender, especially LGBTQ , are particularly interesting issues, and investigating them in regard to accessing professional health care could add depth to this research.

The findings indicate that the women have endured difficult experiences in their lives not shared by white women, and they described some of those situations. Eva explained that she went to a therapist and had this experience:

> I heard them in the back kind of laughing and giggling about my name. And that's something that's already sensitive for me. So, I felt like if I'm going to be

> receiving help from these people and I'm hearing them kind of, like, laugh about just my name, I'm not comfortable to then tell them about my whole life information if you're going to already start (by) laughing at my name.

Limitations of the Current Study

Several factors limit the ability to generalize this study's findings beyond the sample population. First, the sample size (N = 25) was small. Variability among subjects was compromised because of the size of the sample. As a result, any definitive conclusions about African American women's perspectives on help-seeking behaviors in relation to mental health care are limited. Also, Generation Y was overrepresented in the sample, but Generation Z was severely underrepresented. In a surprising finding, one of the two participants from Generation Z was comfortable with talking to family and friends about mental health. It was expected that Generation Z would be more open to seeking professional help.

Second, the participants self-selected to participate in this study, and results were self-reported. Both conditions entailed a degree of uncertainty, the former about data that was unintentionally omitted, the latter about the accuracy of the data reported. Some women chose to participate but forgot their assigned time for an interview. Self-selection eliminated whatever insights or perspectives that the women who chose not to participate may have possessed. Additionally, the women's self-reports could have been impacted by the factors such as the mere presence of the researcher causing the participant to present themselves as socially desirable or limited, causing a defensive reaction to the questions.

A third limitation is that the interviews were conducted virtually due to COVID-19. The interviews were originally planned to be conducted in person, but the pandemic forced a change in the format. Conducting virtual interviews severely limited the researcher's ability to recognize nonverbal expression and eliminated the possibility of a natural setting.

A fourth possible limitation to the study may be the lack of personal pronouns beyond the feminine singular to refer to individual participants. That omission may have unintentionally excluded LGBTQ respondents from employing pronouns that they believe reflect their identity. It also may have foreclosed the extension of intersectionality to LGBTQ in addition to women and African Americans.

The final limitation is that researcher's bias or expectancy may have unintentionally structured the way that the analyses were conducted. The researcher's perspective is implicated as well. One lesson of this study is that in qualitative research, the researcher should clearly state their perspective concerning the construct or phenomenon under investigation. The researcher believes that it is acceptable to rely on oneself, church, family, and friends for help, but it may also be beneficial to seek help to learn certain skills that only a professional can teach. The researcher also believes that younger generations are more receptive to seeking professional mental health care than older generations. In addition, the researcher conducting this study is an African American woman unaccustomed to help-seeking behavior in relation to mental health care; nonetheless, the researcher aspires to help change the paradigm in the African American community of avoiding professional mental health care. The researcher's

experience and intentions may have led to biases influencing the perspective of the questions that were asked and the use of grounded theory.

Future Research and Advocacy

The important topic of African American women not seeking professional mental health care has been much discussed but still lacks a solution. Although a major movement concerning mental health awareness continues around the world today, a large portion of the African American population struggles with mental illness unaided. This study intended to provide new information on the topic and answer some pressing questions. One goal of future research should be to focus on how the field can improve in making the African American community more comfortable, better heard and understood, and just as importantly, better represented in the field. Only 4 % of psychologists in the United States are African American (Lin et al., 2018). An even lower percentage of other mental health providers are African American. A clear discrepancy exists between the number of African Americans suffering from mental health problems and the number of African American mental health providers and psychologists. This indicates that African American not only have difficulty finding a licensed professional with openings, but also with finding a professional who looks like them and has shared similar experiences (Pappas, 2021). To bridge the gap, the field of mental health would do well to foster mentorship to help African American students cope with the challenge of completing rigorous graduate programs and to provide financial support enabling African Americans to enter and remain in the field. In doctoral programs in clinical psychology, the first two years are crucial in determining whether African American women remain in the program or leave (Maxell-Harrison, 2019). According to Maxell-

Harrison (2019), documented experiences of racism and racial microaggressions are common in educational settings. African American women are misrepresented as less intelligent and capable than their fellow students. Not only the isolation that stems from underrepresentation but the perception and experience of racist environments may trigger feelings of depression, anxiety, and alienation, as well as other mental health issues (Maxell-Harrison, 2019). Cultural competency is deplorably neglected in the curricula of graduate programs in psychology. Most programs have one or two courses intended to cover all multicultural identities, which is not nearly enough to prepare students to work in the nation of minorities that America is rapidly becoming. Maxell-Harrison (2019) stated that the field of psychology has not purposefully reflected on the contribution of African Americans to the sociohistorical aspects of the field. More specifically, African American women have been omitted from psychology's professional discourse and are scarcely mentioned in psychological theory and research (Maxell-Harrison, 2019). According to Parham (2002), African-centered psychology is concerned with defining African Americans' psychological experiences from an African perspective, one that reflects an African orientation on the meaning of life, on the world, and on relationships with others and one's self (Parham, 2002). The field could collaborate with collectives like sister circles, which have been created as safe spaces for African American women to heal with other women who share their experiences. Sister circles expand mental health access to the community through churches, sororities, and many other organizations (Pappas, 2021). The field can gain an understanding of what it is about these groups that makes African American women feel comfortable with seeking help from them and apply those insights to the delivery of professional mental health care.

Research has found that it is imperative for mental health providers to demonstrate competency in African American culture in order to have a higher probability of engaging African Americans in treatment (Parham, 2002). According to Pappas (2021), due to the shortage of African American professionals, whites and other professionals must educate themselves about their African American patients' specific needs. It begins with developing an awareness of biases and privileges in relation to race and gender and striving to understand how systemic racism and sexism pervade American society (Pappas, 2021). In treating African American women, the therapist must recognize their pain and resilience, sorrow and strength (Pappas, 2021).

A second goal is to focus on helping African American women translate those qualities into a willingness to accept treatment for themselves. The participants in this study recounted positive reflections about guiding people who were going through a stressful time to seek professional help, but why do they not extend that empathy and wisdom to themselves? The Strong Black Woman schema acknowledges that African American women are often the providers and the core of their families. With that strength comes sacrifices that African American women make that have detrimental impacts on their lives. As the literature demonstrates, African American women often care for those around them but have limited time to care for themselves. African American women offer compassion to others who share the same struggles but may deny it to themselves as a weakness. Mental health professional must help African American women to learn compassion for themselves, and that it is no weakness but rather an extension of their strength.

A third goal would be explore the perspectives on mental health and help-seeking behaviors of African American women who identify with the LGBTQ community. Their experience may differ from that of cisgender women, because they identify with three oppressed groups, which makes them even more vulnerable to life stressors. Studying their views on seeking help from a mental health professional would be interesting and useful.

A final goal would be to examine how the Black Lives Matter (BLM) movement and recent events impacted African Americans' lives, especially in the past year. The outrages against African Americans that were protested so ardently were not new, unprecedented events, nor are they likely to cease anytime soon. Discussing whether recent events increased African Americans' need to seek treatment or the importance of mental health literacy in their households may contribute to change in the African American community. The last question in this study's semistructured interview focused on the BLM movement. Several of the women remarked that they had no idea how it impacted them until answering that question, and they now wanted to seek treatment for their children to help them process recent events in this nation. It would offer an unprecedented opportunity to research more deeply African Americans' thoughts about the BLM movement in general, such as whether they feel supported by or connected to the movement, if they would like to be active in the movement and to what extent, and what outcomes they hope result from the movement itself. If, as the responses of these women to the last question indicate, one outcome has been to prompt more openness among African American women to professional mental health care, that is no small victory for the BLM movement.

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Appendix A

Recruitment Post

I am seeking African American women as participants in a study whose goal is to better understand African American females' perspectives on seeking professional mental healthcare. Your participation will be completely voluntary. Each participant must self-identify as biologically female and be at least 18 years old. If you meet the criteria and are chosen as a participant, you will be asked to complete a brief questionnaire and to undergo a semistructured interview. If you are eligible to participate and complete the questionnaire and interview in their entirety, you may enter a secure raffle with a chance to win one of three $25 gift cards. This study is approved by the Institutional Review Board of Philadelphia College of Osteopathic Medicine (IRB#). The responsible investigator is Kristine Smalls, who is under the direction of Beverly White, Psy.D., principal investigator.

If you understand this project's nature and terms of participation and wish to participate, please click the following link: https://redcap.pcom.edu/surveys/?s=CA44HDHEEX

Appendix B

Demographic Questionnaire

Participant Pseudonym: _____

Do you identify as a female?

A. Yes
B. No

Are you African American?

A. Yes
B. No

What is your age?

_____

What is your level of education?

A. High school (12th grade)
B. Some College
C. College
D. Graduate level

If employed, what is your occupation? If not employed, please enter unemployed.

_____

Are you in a relationship?

1. Yes
2. No

How would your partner racially identify themself:

_____

Do you have children?

1. Yes
2. No

How many? What ages?

What is your annual household income?

A. Less than $25,000
B. $26,000 - $50,000
C. $51,000 - $100,000
D. $101,000 - $200,000
E. More than $200,000

Do you have access to free Mental Health services?
1. Yes
2. No

Do you have insurance that covers Mental Health services?
1. Yes
2. No

In what geographic region do you live?

How would you describe the location where you live?
A. Rural
B. Suburban
C. Urban

Do you have a religious or spiritual affiliation?
A. Yes
B. No

If you have a religious or spiritual affiliation, how often do you attend religious services or practice spiritual exercises?
A. Regularly
B. Occasionally
C. Hardly ever

Please identify your social supports.
Check all that apply:
Family
Friends
Church
Community
Other (Please explain)
_____

Appendix C

Semistructured Interview:

1. How would you describe mental health?

2. How would you describe mental illness?

3. Where or from whom did you learn about mental health illness?

4. Can you share some of the positive and negative messages you received?

5. If you or someone you know has been suffering from a mental illness, what was your experience knowing that information?

6. If you were having a problem related to your mental health, what supports, groups or resources would you turn to for help?

7. If you have sought help, what was your experience seeking and receiving help?

8. Does your perspective on seeking help for your physical health differ from your perspective on seeking help for your mental health? If it does differ, in what ways?

9. If you have needed help for a mental health issue but did not seek help from a mental health professional, why not?

10. How much has the Black Lives Matter movement impacted your need for or willingness to receive mental health treatment?