

Older, Church-Going African Americans' Attitudes and Expectations About Formal Depression Care

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Abstract

This phenomenological study involved focus groups with church-affiliated, African American women and men ($N = 50$; ages 50 and older) in southeast Michigan to determine their attitudes and expectations around formal mental health care. Data analysis employed a constant comparative approach and yielded themes related to formal mental health care, along with delineating concerns about defining depression, health, and well-being. Health and well-being were defined as inclusive of physical and spiritual aspects of self. Churches have a central role in how formal mental health care is viewed by their attendees, with prayer being an important aspect of this care. Provider expectations included privacy and confidentiality; respect for autonomy and need for information, having providers who discuss treatment options; and issues related to environmental cleanliness, comfort, and accessibility. Implications include providing effective, culturally tailored formal depression care that acknowledges and integrates faith for this group.

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Older adults are a rapidly growing segment of the population and health-care providers are increasingly sensitive to their needs for culturally sensitive and community-based care. The needs of older adults are also at the forefront of changing health-care policy. For example, the U.S. Department of Health and Human Services' initiative to improve the nation's health, *Healthy People 2020*, has prioritized increasing community-based and culturally appropriate interventions for the prevention of physical and mental illness (U.S. Department of Health and Human Services, 2013). Major public health initiatives have focused on community as the setting of interventions aimed at improving health and quality of life and mitigating chronic illness (Center for Disease Control & Prevention, 2013; Jacobs, Jones, Gabella, Spring, & Brownson, 2012; McLeroy, Norton, Kegler, Burdine, & Sumaya, 2003).

Fewer initiatives have focused nationally on mental health-care disparities and utilization, specifically concerning African American elders' expectations and attitudes about formal mental health care and depression. The current study addresses this gap in the literature by giving voice to the shared experiences of older African American participants in six focus groups and discussing questions of cultural stigma, perceptions of services, and expectations of access and care by professional providers offering mental health services to their community.

Mental Health and African American Elders

African American elders bear a disproportionate burden of chronic illnesses and have a shorter life expectancy than their White counterparts, making mental health disparities in this population particularly problematic, given the association between increased risk of morbidity and mortality linked to mood and anxiety disorders (Constantine, 2007; Reynolds, Haley, & Kozlenko, 2008). Accurate prevalence rates of depression in African American older adults are difficult to pinpoint, but research suggests that more than 25% of all older adults in community settings struggle with depressive symptoms (Zivin, Wharton, & Rostant, 2013) and that intragroup proportional rates may be roughly the same across racial groups (Diala et al., 2001; Payne, 2012). Some research suggests that African American older adults may be as much as 44% more likely than their White counterparts to

experience the onset of depression over a 10-year period, but that they may remain less likely to seek out formal mental health care and may be substantially less likely to be prescribed antidepressant medication or evidence-based treatments as White adults (Hansen, Hodgson, & Gitlin, 2015; Mitchell, Watkins, Shires, Chapman, & Burnett, 2015; Office of Minority Health, 2014). Older adults who struggle with depression or depressive symptoms utilize more health-care services (such as emergency room visits and hospitalizations) than their nondepressed counterparts (Chapman & Perry, 2008; Himelhoch, Weller, Wu, Anderson, & Cooper, 2004; Huang et al., 2000; Zivin et al., 2013). Despite this, robust evidence suggests that many African Americans over the age of 60 mistrust aspects of the health-care system, for both cultural and experiential reasons (Armstrong et al., 2013; Kennedy, Mathis, & Woods, 2007). As such, these attitudes are often-times negatively correlated with service utilization (Conner et al., 2010; Conner, Koeske, & Brown, 2009). There is evidence that the stigma of mental illness and treatment, coupled with mistrust of care providers for both mental and physical health, makes identifying and implementing needed interventions particularly complex (Payne, 2012; Sanders-Thompson, Bazile, & Akbar, 2004). Cultural perceptions of mental health conditions may be deeply tied to community engagement and spirituality, and the effects of these beliefs have a strong impact on patterns of help seeking and expectations of formal providers, when care is sought (Mengesha & Ward, 2012; Payne, 2012; Watkins, 2012a; Watkins, Walker, & Griffith, 2010). Additionally, misdiagnosis of depression in African Americans is high, and language used to describe symptoms is often different than might be seen in their White counterparts; for example, descriptive (“downhearted,” “blue”) rather than clinical (“depressed”); Givens, Houston, Van Voorhees, Ford, & Cooper, 2007; Matthews & Hughes, 2001; Mitchell et al., 2015).

The Role of Churches in Mental Health Care for African Americans

Over the last decade, the acknowledgment of depression as a medical illness has expanded, and orientations toward evidence-based interventions have accordingly shifted, leading to a more medicalized view of treatment. Once disregarded by medical professionals, spirituality and religion have recently been incorporated into treatment considerations for individual well-being (Mengesha & Ward, 2012). Current conceptualizations of health and treatment have begun to recognize the role of spirituality in an individual’s life, as well as aspects of belonging and social network support found in religious or faith-based groups, particularly for African American adults (Chatters,

Taylor, Woodward, & Nicklett, 2015; Mengesha & Ward, 2012; Watkins, Wharton, Mitchell, Matusko, & Kales, 2015). This tension between the medicalized view of depression and the perceived spiritual and social underpinnings of mental health issues is evident in the literature (Pearce et al., 2015; Rojas-Fernandez, Miller, & Sadowski, 2010) and provides the context for understanding how participants in this study conceptualize depression and the need for care.

African American churches are the cornerstones of many communities, serving as facilitators in the healthy development of individuals both young and old (Dessio et al., 2004; Taylor & Chatters, 2011; Watkins et al., 2015). For many African American communities, the church offers spiritual healing and rejuvenation as well as community-based mental health interventions to improve and maintain the well-being of its members (Chatters et al., 2015). The goal of community-based intervention is to work with existing infrastructure and social systems, in order to support the experience of the consumers who live within them. Grounded in Bronfenbrenner's (1994) theory of social ecology, successful community-based interventions require an understanding of multilevel systems in order to engage individuals within their current social networks and contexts.

Community-based interventions are poised to address disparities in mental health care among older adults; however, there is a dearth of evidence on existing mental health infrastructures and social systems to support African American elders within a church context. Because of a preference among older adults to utilize the trusted services of pastoral counseling over professional mental health services (Hankerson & Weissman, 2012), clergy often act as gatekeepers for more specialized and formal mental health treatment. Therefore, the current study examined qualitative data from older, church-going African Americans to explore issues relevant to their attitudes and expectations around formal mental health care.

Data and Method

Research Design

This is a secondary data analysis of the "Attitudes, perceptions, and beliefs pertaining to mental health, depression, and depression care of elder African American church attendees" study, funded by a pilot grant (awarded to the second author) from the National Institutes of Health and the Michigan Center for Urban African American Aging Research. The study solicited information from a nonclinical population and used qualitative data

collection methods to deepen understanding of participants' attitudes along with factors that may impact their treatment seeking and coping strategies for depression. The sample used for this study came directly from the community. Given the stigma associated with mental health in the Black community, eligibility criteria for the study did not require a mental health (or depression) diagnosis. This is because the primary researchers were interested in capturing community-based information about depression treatment and expectations therein, so as to provide insight into how African American communities perceive treatment for adults over the age of 50, especially in the context of the Black church.

Focus groups successfully capture topical complexities through observation of the group interaction and dynamics that help to elicit in-depth thought (Ulin, Robinson, & Tolley, 2005; Watkins, 2012b; Watkins & Gioia, 2015). Therefore, the original study used focus groups to understand participants' knowledge, attitudes, and beliefs about depression and depression treatment. The current data analysis used the full transcripts from the focus groups and explored the issue that was raised by participants regarding engagement with formal care for depression. The institutional review board approved the study protocol for both the original study and our secondary analysis.

Sample

The sample for this study was taken from a study conducted in 2011 with African American male and female elders at predominately Black churches in southeast Michigan. The purpose of the original study was to examine the role of beliefs, attitudes, and other factors related to adherence to depression treatments among African American adults. The sample was chosen based on voluntary participation, following verbal announcements from the clergy during church services and distribution of study fliers in the churches. Participants were all African Americans, English speaking, and at least 50 years of age. Fifty dollars were provided to each person as an honorarium for their participation. This amount was decided in consultation with the church leadership, in order to identify an appropriate amount that would limit the potential for perceived coercion while appropriately recognizing the time given by participants in the focus groups. The study engaged a total of six focus groups that totaled 50 older adults (21 men and 29 women). Groups were limited to 6–10 people to maximize discussion and provide the maximum flexibility for the facilitator to moderate the discussion if needed, and men's and women's groups were offered once at each of the three churches. No additional recruitment or groups were conducted.

Data Collection

Two focus groups were conducted in each of three participating churches—one each for men and women—for a total of six groups. The same focus group question guides were used for all six groups and included questions related to (1) participants' experiences with depression, including common terminologies used to describe depression, (2) participants' perceptions of depression treatments including therapy and antidepressants, and (3) the role of the church in depression care. Focus group questions did not use specific language from the *Diagnostic and Statistical Manual* (DSM; American Psychological Association, 1994) for mental disorders but instead used open-ended questions to gauge responses from participants and elicit discussion. Gender-matched and racially concordant members of the research team guided the focus group discussions by asking semistructured questions and keeping participants on topic. Further probes and/or clarification, as appropriate, followed each question. The male and female groups in each church ran concurrently to prevent discussion or sharing of information between sessions. Each session lasted 60–90 min. The discussions were digitally recorded, and another member of the research team took observational notes during the session. The audio recordings were transcribed verbatim and deidentified. For this study, transcripts and session notes for all groups were analyzed. The study team decided a priori to analyze all transcripts, so determining a saturation point in this study was not applicable, although saturation was reached.

Data Analysis

The qualitative analysis was guided by a team approach (Watkins, 2012b) supervised by the second author. The study team used a spreadsheet technique to organize, manage, and analyze the data (Stockdale, 2002; Swallow, Newton, & Lottum, 2003; Watkins & Gioia, 2015). First, a word processing program was used to place all of the data into a table with multiple rows and columns. The development of this spreadsheet, or all-inclusive "data table," was followed by developing seven column headings: transcript number, questionnaire section, question asked, participant's response, notes, code, and theme. After the data table with column headings was created, the team used a data reduction technique (Watkins & Gioia, 2015), which involved using this all-inclusive data table to produce shorter, more concise data tables. In order to reduce the table, the study team members each reviewed the all-inclusive data table and made notes about areas of commonality and

overlap across groups or between participants and then generated opinions about the relevance of certain quotes and the intersection of concepts. The team subsequently met together to review notes and discuss concepts. Any disagreements were resolved in discussion among the authors. This process was repeated with each iteration of the data tables. For the purposes of this study, four different phases of the data reduction tables were created and each signified a more narrow and specific presentation of the data.

A two-level coding process was used (Watkins, 2012b). First, the preliminary coding identified text segments that were used to identify categories, concepts, and themes important to the overall project goals and objectives. During this level of coding, data were analyzed using classical content analysis, which involved identifying the frequency of codes to determine which concepts were most cited throughout the data (Leech & Onwuegbuzie, 2008; Watkins, 2012b). For example, formal mental health-care environment was identified as a frequent code that required further analysis. Therefore, a more focused level of coding (Watkins, 2012b; Watkins & Gioia, 2015) was used to identify constructs within that code, such as accessibility and cleanliness of the mental health-care environment. The team used constant comparative analysis to generate a theory or set of concepts (Leech & Onwuegbuzie, 2008) that further elaborated on these constructs. The purpose of this level of analysis was to acquire a deeper understanding of how participants experienced the environment of formal care providers and what their needs and expectations were regarding the environment of care.

Results

Sample Demographics

A convenience sample of 50 African Americans, aged 50 and older, who attended one of three churches located in southeast Michigan was recruited (see Table 1). The final sample included 21 men, ages 50–87 years old (mean age 59), and 29 women ages 51–94 years old (mean age 67). The majority of these individuals were retired, although the younger participants self-identified during discussions as being in careers including nursing, medicine, and labor careers, indicating a range of unique experiences and perspectives in the workforce. Additional demographics are provided in Table 1.

In both the men's and women's groups, participants spoke about their wariness to access formal care for depression, and how such actions would generally be taken after all other methods of informal intervention and recovery had been attempted. Informal interventions usually included prayer

Table 1. African American Focus Group Participant Demographics.

	Men (n = 21)		Women (n = 29)	
	Total	Percentage	Total	Percentage
Age	50–87 years		51–94 years	
Years of education	6–18 years		12–18 years	
Involvement in church				
Staff	7	33	3	10
Member	17	81	23	80
Chairperson/frequent volunteer	5	24	12	41
Regular attendee	12	57	22	76
Nonmember/infrequent Attendee	0	0	1	3
Not reported	1	5	0	0
Physical health				
Excellent or very good	9	43	10	34
Good	7	33	8	28
Fair	4	19	10	34
Not reported	1	5	1	3
Emotional health				
Excellent or very good	9	43	17	59
Good	9	43	7	24
Fair	2	10	2	7
Poor	0	0	1	3
Not reported	1	5	0	0
Highest degree earned				
High school/Equivalency	9	43	14	48
Associates degree or bachelor's degree	12	57	9	31
Master's degree	0	0	4	14
Not reported	0	0	2	7
Income				
Less than US\$20,000	3	14	8	28
US\$20,001–US\$30,000	3	14	3	10
US\$30,001–US\$40,000	6	29	5	17
US\$40,001–US\$50,000	4	19	6	21
US\$50,001–US\$60,000	3	14	0	0
More than US\$60,000	2	10	5	17
Not reported	0	0	2	7

and connecting with the church community, among other things. This lens provided an important context through which we generated and interpreted our results. Therefore, in the subsequent paragraphs, we present our interpretation of how participants discussed mental health in the context of the church, prior to reporting the study's overall themes and subthemes.

The Context of the Study: Mental Health in the Context of the Church

Themes around attitudes and expectations of formal mental health care cannot be divorced from the larger context of how depression is defined by our participants. Participants in our focus groups frequently used examples from their encounters with physical health providers to illustrate points about needs and expectations of mental health care. They tended to view mental health as distinctly different from physical health, despite a recurring assertion that their “self” consisted of multiple parts and that spirit and physicality are intimately tied. One man expressed this sentiment, when he explained that “our spiritual world and our physical world are totally intertwined, you cannot separate them. Period.” Although several of the women acknowledged depression as a “chemical imbalance,” there was a consistent theme among both men and women that depression was related to a lack of religious faith and isolation from the faith community. While men in this study tended to ascribe depression to situational experiences or role-related issues, women viewed it primarily as a weakness or spiritual void. One man expressed this theme by saying “My religion can take care of depression,” while another explained that “. . . Just about every social and most emotional and mental problems that people incur in life is actually a spiritual problem in disguise. . . go to God first.”

The church as both a physical and spiritual place took a central role in perceptions of mental health and formal mental health care in this study. According to the participants, a church community embodies abstract concepts of faith and God, as well as more tangible connections and behaviors (e.g., prayer as intervention, pastors who endorse and validate help seeking for formal care, and social network support that helps to mitigate isolation and ensure continuing activity for older community members). However, even when strong social support exists and clergy members value and endorse treatment for mental health, substantial stigma remains regarding help seeking for mental health related issues in some communities. Men’s focus group members elaborated, “. . . nobody wants to be perceived as weak”; several men specifically spoke about the stigma within the church community: “. . . especially in the Black church, we tend to look at it as negative. . . Most Black churches tend to look down on that.” Despite the stigma, many participants articulated that they perceived professional help as being delivered by God, and they felt a responsibility to use these resources that God had provided.

Study Themes and Subthemes

Findings from this study centered on three major thematic clusters: attitudes and expectations about formal mental health care, the formal mental health-

care environment, and medications, personal integrity, and communication in depression care (see Table 2).

Theme 1: Attitudes and expectations about formal mental health care. Embedded within the context of participants' definitions of culture and community, three subthemes related to attitudes and expectations emerged from the focus groups: concerns about formal care, issues related to trust, and issues related to credentials and training.

Concerns about formal care. Participants discussed issues related to privacy and confidentiality, respect, trust, and the educational training of providers as important to engaging formal mental health services. Both women and men in this study spoke about the importance of being assured that they could confidentially seek and receive help for mental health issues. Specifically, participants were concerned about maintaining anonymity while entering and exiting mental health-care offices and working with clinicians who would fully protect their privacy so as to avoid being stigmatized or labeled by people from their communities. Some participants noted that the risk of a mental health provider discussing their personal issues within earshot of social spaces would be enough to discourage them from seeking help.

Some participants were reluctant to see anyone but their normal physical health-care provider. This is significant because mental health care is increasingly taking place in primary care settings where older adults may be screened for depression and/or treated with medications to address mental health conditions. If individuals are less inclined to disclose mental health symptoms in the presence of an unfamiliar health provider, those individuals may be less likely to receive appropriate care or have their symptoms adequately managed over the long term. One woman clearly explained this phenomenon saying,

If I went in and I normally see one certain doctor and then all of a sudden somebody else steps in I don't know then I'd be like, 'Oh I'm not going to discuss this with him' because you don't feel that comfort zone.

Closely related to the issues of privacy and confidentiality is the issue of respect, across all types of care. Participants wanted to be seen as actual people and not part of a caseload, implying that this level of respect is deeply tied to the quality of care they expect to receive and their likelihood of returning or following through on treatment. One man stated, "I don't want

Table 2. Subthemes and Selected Participant Quotes.

Subtheme	Context	Selected Quotes
Mental health in the context of the church	Participants in the men's focus group discussed a sense of stigma around mental health issues in the church, and one man provided this example	People are, you know, they're very scared . . . you still got people still in that same stigma today . . . it's going to take a lot to get them to go and speak to some, you need some professional help, you can't just get it all from your friends and your neighbors and your family and if you come and ask the pastor of this church here, he will send you to a counselor, where I know as some churches they might try to, you know, brush over that, "Oh we can just lay on holy hands and we can just pray about this".
Concerns about formal care	One woman provided a good example, as she described an insensitive inquiry that shut down her willingness to engage in any further treatment	First he made me angry because he asked me a question, which, oh, due to my age, uh, "Were you ever on drugs?" I said, "What makes you think I ever done drugs?" Well you know, you were this age . . . a lot of young people when they're you know, back in the '60s taking drugs, I said, "Everybody didn't take drugs, everybody don't do everything, you know, as a people" and I got offended with him and so therefore, he couldn't do me any good from then and forth.
Trust	One man provided an example from his own church regarding the trust he has in mental health professionals available through the church	We are very fortunate in this church because we have some highly professional people who are available or who can send us in the direction of someone who is available and the mere fact that we are like brothers and sisters here, we trust that person, that they are going to do this in a, if we want it to be kept a secret or we just don't want the public in general to know, again, back to that stigma situation. We think that they would do the proper thing to prevent that happening.

(continued)

Table 2. (continued)

Subtheme	Context	Selected Quotes
Credentials and training	One male participant provided an example, as he described his expectations about credentialing	... credibility ... I'm very adamant about whether he's a PhD or he's a PhD-MD, which tells me a lot about him... when I look at those credentials, then I'm more comfortable that way.
Cleanliness and comfort	One woman gave an example of what makes a difference in her willingness to return to someone's office for future care or to discuss challenging issues	If you make a special effort... She has real cushy chairs that you would have in your living room. She has baskets instead of having the cabinets that they have and she has a, her whole manner is, she's very calm and she spends a lot of time with you... a lot of your physicians, they only want to hear what hurts, you know, and especially if you have chronic illnesses, that's all they really want to hear and they don't talk to you about those issues. So you have to have somebody that, you know, you have that rapport with and they're interested in more.
Accessibility and timeliness	One woman gave an example, as she described the need for accessible and timely care	I'm not going to say that the doctors, the psychiatrist is not okay, ... but we need someone that we could call without having to make an appointment. We need to have someone in our life, whether it be a mother, an aunt, a grandma, someone that we can call when we're down and out and so they can give us just what we need at that particular time because maybe waiting until next week for an appointment may be too late.

(continued)

Table 2. (continued)

Subtheme	Context	Selected Quotes
Medication and related treatment issues	Two different participants gave examples of what the group felt was a common experience in depression screening in primary care, sharing both the attempt at treatment and response	When you do go into the doctor and tell them you're depressed, what's the first thing they do? They put you on medication that makes you feel worse than you already did—antidepressants. I had to flush them down the toilet. Don't just because a person say they depressed or down and out start pumping pills in them, that's all I'm saying.
Personal integrity	One of the women gave an example, as she explained the necessity to consider both the physical and spiritual aspects of health	The people you have in your group today, we have a common belief: we're 2-part—spiritual and humanistic and in this world, you know, the humanistic, we get sick, all different kinds of things, depression, whatever the case may be. But then still, it's our faith and if you take the pills . . . you take it in two parts . . . some people, they take all the medication, they never get any better, and never get, you know, it's down spiral because it's the spiritual part and we believe we're both spiritual and humanistic and that spiritual part sometimes thank God, overrides whatever else is going on.
Communication	One woman gave an example, as she described her experience around receiving limited information and follow-up related to starting a new course of treatment	“Okay, I'm going to put you on this” and a lot of times . . . I'll go out and get the medicine and I'll go home and I'll hold onto it for 2–3 days and then “Oh okay, do I want to take it?” and you know, you go through the cycle. “Well do I want to take this particular medicine, because I know what it's going to do” and you never even took it but you already know, you think you know what it's going to do. So okay, well I don't want to deal with that and then, you know, you end up taking it and it's not what you think it's going to do. It works for what you need it for, so I think that happens to a lot of us.

to come in there and feel like a number, where he looks at me, he reads a paper, give you something and say, ‘Okay, you’re done.’” An important aspect of respect is related to sensitivity and not making assumptions about experience or need based on things like societal trends and generalizations (see Table 2).

Trust. Focus group participants spoke repeatedly about the important role of pastors and other supportive individuals within their faith communities in encouraging them to seek help for mental health issues. They described uniquely trusting the members of their faith communities as a result of strong familiarity and shared experience and values. Trust in the pastor and known members of faith communities provided a doorway through which people could seek advice or referrals while minimizing fears related to stigma and disclosure.

Credentials and training. Participants indicated a desire for individuals in the helping professions to be both well trained and appropriately credentialed. There was a general sense that while respect and familiarity is expected and necessary in mental health-care patient-provider relationships, being overly familiar in tone could signal a loss of professional composure, regardless of the context. Several participants recalled meeting their health-care providers in social or public spaces and feeling uncomfortable or disappointed to be observing them engaged in mundane activities. One man described this issue from his perspective: “I wouldn’t want a doctor that I felt was my equal. I would want a doctor that I felt was superior to me, somebody that could help me.”

Theme 2: The formal mental health-care environment. The physical environment and ability to have access to care in a timely fashion both emerged as prominent concerns among participants, particularly with regard to how welcoming a space seems to be, and timeliness of the availability of services relative to when crises occur.

Cleanliness and comfort. It is not uncommon for the behavioral health specialist working with a primary care office to visit with patients in the examination rooms or for clinicians to have sparsely decorated interview rooms in an outpatient clinic. For these participants, however, the care and attention given to creating a welcoming space signaled the kind of person the provider may be and how welcoming and valued the care. In addition to the physical comfort of the environment, the presentation of the provider plays a role in willingness to engage in care. Unkempt dress or hair or off-putting

tone of interactions was a trigger for nonreturn, regardless of the reason for care.

Accessibility and timeliness. Unsurprisingly, the need for timely care was a topic of discussion among these participants. They spoke of their unwillingness to seek emergency room care for crises, because of the hours that would be spent waiting for attention. Similarly, several participants made note of the challenges of getting in to see a formal mental health service provider when appointments were necessary weeks in advance. The concept of accessibility was inclusive of physical convenience coupled with the timeliness and confidentiality of encounters; these thoughts were often interspersed with how informal support could meet those needs.

Several men suggested making contact information for mental health providers easily available on the Internet, including mechanisms that immediately facilitate help seeking and access to regular care. These men expressed wanting confidential information or mental health screening contained within a prompt initial response (i.e., phone consultation or walk-in appointment). One man noted that he would like to “have a doctor’s name that can ask questions over the phone or over the Internet and if they need to go further, . . . they can talk and they can schedule.”

Theme 3: Patient-oriented care. Participants in these focus groups raised concerns about medication, counseling, and the need for providers to consider the person more holistically, using a patient-perspective orientation, beyond prescribing medications. Subthemes emerged from the data through three constructs: medication and related treatment issues, recognition of self as an issue of personal integrity, and clear communication around care decisions.

Medication and related treatment issues. While participants who engaged in these discussions were not universally opposed to taking medications as part of depression treatment, they tended to view the medical profession as relying on medication as an initial response to all problems. Such an approach often discounts the wholeness of the person and the nuances of their lived experience. Participants agreed that providers who failed to engage with the story of the patient or to establish a clear partnership in the treatment process would likely struggle to provide effective care or garner a patient’s full cooperation.

Many participants expressed a hesitance to taking medication. This reluctance may involve a range of things, but whether misunderstanding, fear of side effects, or lack of belief in the treatment modality, the act of prescribing an antidepressant without concurrent adjunctive intervention was seen as

disregarding personal integrity. Several participants endorsed this idea; they indicated that intervention by providers needed to engage with the larger context of the patient's life in order to get an accurate understanding of both context for impairment and willingness to participate in pharmacotherapies; as one woman put it, "the prayer, the medication, the counseling, the whole gamut." In response to a question about whether he would consider taking medications for depression, one man clearly explained that it would be a decision made under duress: "It'd have to be the last resort. I would be reluctant to but again . . . it would have to be proven beyond a doubt. It'd have to be the counselor, the doctor, and the drug."

Personal integrity. There was considerable discussion in the focus groups about the integrity of the personal self, and the notion that individuals are more than just a diagnosis and more than a physical entity. Just as their concept of depression encompassed aspects of spirituality, so too does their conceptualization of overall health and well-being. Addressing symptoms related to mental health issues may be one aspect of treatment, but without addressing the larger social context of the individual, such interventions are ineffective at best and harmful at worst.

Communication. Participants reported that communication and a provider's ability to provide health education was key to initiating adequate care for them. Closely tied to the previously discussed concepts of respect and recognition of wholeness is the idea that patients have autonomy and expect that they will be provided adequate information that will allow them to make health-care decisions for themselves. When engaging in dialogue with patients, participants noted that often conversation progresses at the pace of the provider with little regard to the clarity or processing time needed by the patient. One woman explained that "Sometimes . . . they'll be talking and . . . you're stuck on one something they've said and they have moved on . . . I'd like to take somebody with me and then the two of us discuss it a bit you know, and then start the medication."

Discussion

As the population of older adults grows exponentially in the United States, the provision of community-responsive and contextually humble formal services for mental health care is critical. Known associations between depression and physical health morbidity raise this issue to one of pressing importance, particularly given the racial disparities in access and utilization of care (Pearce et al., 2015; Sanders-Thompson et al., 2004). African

Americans are consistently underrepresented in mental health care, and older adults are particularly vulnerable to receiving inadequate or inappropriate responses to their health-care needs (Conner et al., 2010; Hansen et al., 2015; Mitchell et al., 2015).

Although this study involved a subset of a much larger and diverse population, it is instructive to consider the experiences and beliefs of this group as a starting point for a broader exploration of what optimal mental health services for similar cohorts might look like. For this community-based sample of older African American adults, a number of things were important to ensure their comfort and willingness to engage in formal mental health services.

Confidentiality and protection from exposure to community stigma were very important to the study participants. Referral or encouragement from a trusted source such as a pastor or respected community member seemed to be a primary gateway for willingness and ability to access formal depression care services. Appropriate training and credentialing was essential, as was the appearance of a degree of social distance on the part of the provider—or more specifically, the ability to be personable, build rapport, and be attentive to patients, while remaining objective and not becoming too socially familiar. Previous studies have alluded to the need for high-quality physician training to improve patient–doctor communication (Paternotte, van Dulmen, va der Lee, Scherpbien, & Scheele, 2015). Likewise, for older, church-going individuals, their physicians' credentials may be especially important, as some research suggests that the credentialing of other authority figures in their lives—such as clergy and other church-affiliated leaders—influences individuals' respect for them and adherence behaviors (Stansbury, Harley, King, Nelson, & Speight, 2012). The need for consistency in providers (i.e., participants were wary when other providers stepped in to replace or substitute the usual person) and an expectation of respect for their individuality and autonomy are both ideas that are consistent with previous literature (Matthews & Hughes, 2001; Sanders, 2005; Waites, 2012).

The environment of offices and accessibility of care played an important part in expectations and attitudes, with welcoming environments and rapid availability likely to increase willingness to engage in both physical and mental health services. While it would be easy to take for granted that the environment in which care is offered is comfortable and inviting, this detail is frequently overlooked in mental health care (Broadbent, Moxham, & Dwyer, 2014; Tsai et al., 2007). Observations about time-delayed appointments for crisis situations and easier access to family or community members for support were notable and should be carefully considered by providers hoping

to offer community-based services. Suggestions such as consulting phone services, Internet-based triage services, or walk-in appointment slots might be worthy of consideration, as a means to opening a wider door to service access in a timely fashion. It is also worthy of consideration that access to an appropriate screening or crisis hotline, staffed by people who are sensitive to the needs of older adults living in the community, might meet this need, while providing a mechanism for further scheduling of care with providers.

Consistent with previous literature (Hansen et al., 2015), there was a distinct expectation that providers should recognize both autonomy and the need to provide health education. Stories of providers prescribing pills and dispensing limited education around treatment choice demonstrated that ignoring this facet of care could undoubtedly impact outcomes and cooperation with provider treatment recommendations. By recognizing the larger context of a patient's life and allowing space for concerns and treatment need to emerge and be expressed, providers may be able to engage patients in the process of selecting an intervention and evaluating its success. While encouraging patients to attend appointments with "listening partners" may be worth exploring, mental health-care providers can enhance willingness to engage in evidence-based treatments by allowing adequate time to explain the evidence, and for discussion and education surrounding the impact of such choices on the life of the patient, in a manner that demonstrates respect for autonomy. Previous studies have found that situations where patients feel that their doctor "never listens" are correlated to nearly twice the incident rate of depression (Mitchell et al., 2015). Additionally, research shows that an orientation toward patient-centered communication, where the individual history and embedded culture of patients is included in the building of rapport are essential to a good patient-provider relationship (Hansen et al., 2015); this study provides additional support for such evidence.

Also consistent with previous research, quality care for depression was described as recognizing individuals as more than simply a mechanical body and addressing linkages between faith or spirituality and health and well-being. It is important to note the willingness of these participants to engage in counseling, and their expectations that provision of a pharmaceutical intervention should be accompanied by supportive therapy. This idea is consistent with the concept of recognition of self as being both physical and spiritual. Statements detailing the deeply intersectional nature of well-being and spirituality were pervasive and accompanied by a widely shared belief that one cannot be addressed without the other. Surrounded by their church community members, these participants reported having social network support that provided them with meaningful and necessary linkages to meet a range of

needs. Providers need to acknowledge and respect the implicit culture of this social network, and the centrality of both the church and religiosity in people's lives, in order to open the doors for individuals to engage in treatment (Chatters, Taylor, Woodward, & Nicklett, 2015; Conner et al., 2010; Waites, 2012).

Limitations

Our findings should be interpreted in the context of a few limitations. First, we used a convenience sample of African American elders from three local churches; thus, the findings are not generalizable to larger populations. The convenience of the sample likely gave rise to selection bias, both among the churches and the study participants. In other words, we understand that the church members who were active participants in our study may have been more aware of depression and depression care and, therefore, more motivated to participate in the study. Second, there are certain limitations that the focus group design may render, such as limits to the full disclosure and articulation of individual perspectives. Finally, while an incentive was helpful in recruiting participants, it may have also resulted in response bias. Barring these limitations, the present study is well positioned to help clinicians move toward more targeted assessment tools for community-dwelling African Americans elders.

Conclusion

This study highlights important issues related to privacy, confidentiality, environment of care, and orientation toward disease, encompassed in the value of respect for autonomy, for personhood, for culture, and for preferences. If mental health professionals hope to provide support and address disparities in care for aging African Americans in community-based settings, they will need to adapt mainstream, medical models of services to include the flexibility in service provision called for in some communities. For example, triage or call-in hours may reassure community members that providers are available when needed, and office space that is designed with older adults in mind, including chairs that are both comfortable and easy to rise from and personal touches to spaces that differentiate them from clinical exam rooms will provide the kind of environment that puts them at ease. Additionally, ongoing training for providers in communication styles that adapt to the individual client is desired, providing ample time for explaining evidence for treatments, options for care that allow both building rapport and shared

decision-making, and engagement in discussions that are responsive to concerns. It is important to note that many older adults are not unwilling to use psychopharmacological interventions for depression, but that they may prefer options such as talk therapy as a first line of intervention. Details such as these must not be overlooked if mental health providers hope to address disparities in access and willingness of older adults in community-based settings to engage in care. Although this study examined critical aspects of the intersection of care provision and access for depression support among African American older adults, we did not explore gender differences on this issue or the intersection of age, gender, and race—something that future research should consider.

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