

When Money Isn't the Issue:
Socio-Cultural Factors in Help-Seeking
among Black Americans with Depression

by

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In loving memory of my grandfather
Isaac Campbell, Jr.

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I can do all things through Christ who strengthens me. – Philippians 4:13

Trust in the Lord with all your heart and lean not on your own understanding. In all your ways acknowledge Him and He will direct your paths. – Proverbs 3:5-6

Do not be anxious about anything, but in everything, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which passes all understanding, will guard your hearts and your minds in Christ Jesus. Philippians 4:6-7

“For I know the plans I have for you,” declares the Lord, “plans to prosper you and not to harm you, plans to give you a hope and a future.” – Jeremiah 29:11

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Abstract

From in-depth qualitative interviews with 17 African American men and women between the ages of 21 and 57, this dissertation examines how socio-cultural factors impact help-seeking and service use among Black Americans with depression. This dissertation accomplishes three main objectives: 1) better understand low service use rates for depression among Black Americans by looking beyond strict financial or access-related barriers and towards more social-cultural factors related to health behavior; 2) explore how culture influences health behaviors, particularly those around help-seeking and service use for depression among Black Americans; and 3) identify targets for intervention to decrease the stigma associated with depression and service use in Black communities and increase service use rates for Black Americans who feel they might benefit from services.

Chapter 2 of the dissertation highlighted the importance of examining socio-cultural understandings of identity, illness, and help. I find that being “Black” and “depressed” often exist as two conflicting identities that, until reconciled, can prevent and/or delay Black Americans’ entry into mental health treatment for depression. In **Chapter 3** of the dissertation, I find that many respondents see Black communities as particularly stigmatizing toward individuals with depression, many times equating depression and treatment with

being non-Black and producing fears of social rejection or ridicule. I also find that many respondents were reluctant to adopt another stigmatizing and potentially marginalizing status, resorting to a sort of double-existence where they hid their depression and sought treatment in silence to maintain both social and professional statuses. **Chapter 4** of the dissertation discussed the impact of socio-cultural beliefs on help-seeking and service use among Black Americans with depression. I find that most respondents reported some impact on help-seeking behaviors, particularly on those that involved disclosing symptoms to or seeking help from non-professionals. **Chapter 5** discusses the directions of future research, namely considerations for intervention research to improve the mental health service use rates among Black Americans with depression.

Chapter One

Introduction

I was sitting in the cabin, passengers all around. The flight attendant was directing our attention to the placard in our seatback pockets that detailed the safety features of the Boeing 737. I listened intently. Then something strange happened: music filled the cabin. Confused, I looked up at the flight attendant. He was singing, right along with music. The passengers were all dancing, the plane was shaking, and he was singing...loudly. The song was familiar. This had happened before. What do I do? Wake up! Huh? Wake up! Why? It's your phone. Huh? Your PHONE!!! The plane, flight attendant, and passengers disappear. I reach for the vibrating, singing phone.

Me: Hello?

Caller: (sniff, sniff) Rosy?

Me: Hey, kid.

Caller: I'm sorry to call...(breaks it tears)

Me: It's ok, sweetie. What's wrong? Bad night?

Caller: (through tears) Yes.

It was call I had gotten before. Truth be told, it was a call I had made before. That's why they call me. They all knew. I had been depressed, severely. I'd seen the inside of a hospital. I had taken meds and spoke

extensively with therapists. And I was better. So, they called. Knowing I'd understand. Knowing I'd listen. Knowing I'd offer them some hope that tomorrow would be better. They looked up to me. They saw me as a "success." Yet, the call always ended the same....

Me: Feel better?

Caller: Yeah, thanks.

Me: Good.

Caller: I'm gonna try to go to sleep now.

Me: Alright, kiddo. Get some rest. Call me again if you need to.

Caller: Ok. Rosy?

Me: Yeah, kid.

Caller: Don't tell anyone I called.

They never wanted anyone to know they called. They never wanted anyone "to know." And I was left with the same feeling. WHY? But I knew why. It was same reason why I didn't want anyone to know. And if it hadn't been for that little trip to the psych ER, no one would have. It is the same reason that keeps many people from seeking help for depression, especially Black people. It is the same reason why I continue to research this topic though I have heard every reason why I shouldn't: "It's been done." "EVERYONE has depression. Why focus just on Blacks?" "(Laughter) Girl, WE don't get depressed." "How much about our people are you gonna be telling folks?" "You plan to publish this?" "That's just your story." But these secret phone calls in the middle of the night tell me it is not just my story. The look on the face of a patient when I tell them I understand why no one knows that they are seeing me and taking

medication tell me it is not just my story. The thank yous I get from study participants after they finish their interviews and the plea that I continue doing “this kinda work” because “we need more of it” tell me it is not just my story.

I thought about the individuals who confided in me about their struggles with mental illness. Most were Black Americans who had access to mental health care through employer-issued health insurance or personal wealth, yet they did not seek help through mental health services. Often time, they refused to. Most of the literature I read on the topic, completed most often with low-income Black Americans, cited a variety of financial and structural barriers to care. But the knowledge that this was not the case for the individuals who sought counsel with me and remembering the variety of responses I received when pursuing this research made me realize that barriers to care extended beyond the financial and structural barriers that dominated the literature, and it was in this direction that I should pursue my research.

Depression and Service Use among Black Americans

Depression is a major mood disorder affecting many men, women, and children in the United States (Kessler, et al., 2005a, Williams, et al., 2007). While the disorder is quite treatable for most people, many of those suffering from this debilitating illness do not seek help (Neighbors, et al., 2007; Williams, et al., 2007). Among those that do seek help, Black Americans lag significantly behind Whites in terms of formal service use (Alegría, et al., 2008; Keyes, et al., 2008; Lasser, et al., 2002; Padgett, Patrick, Burns, & Schlesinger, 1994; Sussman,

Robins, & Earls, 1987; Williams, et al., 2007). Also troublesome is that while rates of depression are lower among Black Americans (Blazer, et al., 1994; Kessler, et al., 2005a; Kessler, et al., 2005b; Williams, et al., 2007), when they do experience depression, the symptoms tend to be more severe and persistent (Williams, et al., 2007).

For many years, researchers have sought to understand, and ultimately eliminate, the racial/ethnic disparities that exist in mental health help-seeking and service use. Most of these studies highlight the impact of financial and structural factors on the decision to pursue help for mental health problems among low-income Blacks. While it is true that Black Americans are more likely than whites to be poor, lack insurance, or live in areas where accessing mental health care is difficult (Ayalon & Alvidrez, 2007; Copeland, 2005; Schnittker, 2003; Snowden, 2001), this certainly does not completely explain the lack of mental health service use among an economically diverse Black American population. Other research has shown that service use among Black Americans still lags behind that of Whites even when financial and structural factors are absent or controlled in analysis (Alvidrez, 1999; Ayalon & Young, 2005; Kimerling & Baumrind, 2005; Padgett, Patrick, Burns, & Schlesinger, 1994; Snowden, 1999).

While financial and structural barriers are the impediments most addressed by the literature, growing concern that differences in service use persisted even after accounting for such factors pushed scholars to look towards more personal and social factors impacting the use of mental health services. These facilitators and barriers to mental health service use are highly influenced

by culture, a factor that is often overlooked or simplified in discussions about racial/ethnic differences in the use of mental health services. Recognizing the importance of socio-cultural factors is crucial to understanding help-seeking behaviors and patterns of service use among Black Americans.

While there is recognition in many fields that culture or related factors impact how Black Americans engage with the mental health care system, some scholars view the use of the concept of culture as problematic. Some researchers have issues with the focus on culturally-specific symptoms as opposed to identifying more universal aspects of illness to aid in crafting more widely applicable interventions in our resource-limited society (Fabrega, 1989). Others may feel citing culture as a factor in behavior (in this case, as a barrier to service use) might be seen or interpreted as blaming the victim for not addressing their (mental health) problems (Small, Harding & Lamont, 2010; Valentine, 1968). With the legacy of the “culture of poverty” theory/doctrine introduced by Oscar Lewis in the 1960s (Small, Harding & Lamont, 2010; Valentine, 1968) and the use of narrow or outdated definitions of culture (Angel & Thoits, 1987; Lopez & Guarnaccia, 2000; Valentine, 1968), these concerns are valid. However, ignoring or pushing against the use of culture in understanding health and health behavior makes research on the subject limited and incomplete.

(Re)Defining Culture

Human behavior and how it is interpreted is highly influenced by culture

(Herskovits, 1972). “Culture plays a [crucial] role in shaping beliefs, value and rule systems, problem-solving patterns, communication styles, and learned coping behaviors” (Matthews & Hughes, 2001, p. 77; Pedersen, 1986). This is also applicable to health behavior and the meanings constructed around illness. Fabrega’s concept of ethnomedicine focuses on the importance and interrelatedness of culture and illness and places emphasis on how social and cultural factors influence the perception, expression and outcomes of medical problems (Fabrega, 1977; Fabrega, 1975). In other words, the way people define and think about illness is heavily dependent upon their social and cultural environments (Kleinman, 1992; Kleinman, 1980b). What is often considered or labeled “normal” behavior and what is deemed “illness” is based on the individual’s cultural group and the beliefs, values, and expectations that exist therein (Scheff, 1966; Capers, 1991). Thus, the experience of illness itself, including how the illness is interpreted and what meanings are attached, and the outcomes including how individuals approach seeking help for what has been identified as an illness, is all shaped by culture (Angel & Thoits, 1987; Bagley, et al., 1995; Good, 1997; Kleinman, 1992; Kleinman, 1980a; Murray, 2001; Olafsdottir & Pescosolido, 2009).

Placing emphasis on cultural differences in health and health behavior has often been criticized as many researchers have looked toward more universal characteristics of illness to help better define and treat various infirmities (Fabrega, 1989). And citing culture in general as a factor contributing to lack of service use can be viewed in scholarship as “blaming the victim” for persistent

psychological distress (Small, Harding & Lamont, 2010; Valentine, 1968). While these criticisms may hold some truth, they should be applied to particular *interpretations* of the cultural study, not the practice itself. If we focus simply on the fact that differences exist in the “beliefs, feelings, behaviors, traditions, [and] social practices” among a diverse populace (Fabrega, 1989, p. 415), we can see how a cultural approach can be helpful when trying to better understand and address low service utilization rates for depression among Black Americans.

In truth, any study that focuses on choice-making behavior indicts the victim. However, if we fail to examine culture or, at a narrower level, beliefs shaped by culture, we miss the opportunity to fully understand all of the factors that impact a person’s decision to seek help for mental health problems. By taking a more culturally “aware” perspective we accept that 1) there is knowledge in understanding culture and 2) recognizing this does not mean that you are making judgments but appreciating and understanding difference.

The Dissertation

In this dissertation, I wanted to better understand racial/ethnic disparities in mental health service utilization by exploring the experiences of Black Americans who had depression. I wanted to look beyond pure financial and structural barriers to care and learn more about how views about depression, help-seeking and service use 1) are influenced by culture, and 2) operate as a potential impediment to care. Through qualitative interviews with 17 Black men and women, I hoped to extract information from their depression and help-

seeking experiences to gain insight on the culture surrounding ideas about illness and help-seeking that may ultimately hinder Black Americans from seeking care from which they feel they might benefit.

Methodology

Gathering information on this topic can be accomplished through a number of means. This dissertation utilized the qualitative interviewing approach. Intensive interviews allowed me to 1) move beyond the surface of experiences and extract more details; 2) explore various statements and/or topics; and 3) ask about feelings, thoughts, perceptions, and behaviors (Charmaz, 2006). This approach was also useful because of the population being studied. Research has shown that when collecting data from African American research participants, this group prefers in-person, face-to-face interviews as opposed to telephone or mail surveys (Burlew, 2003). Thus, this more qualitative approach contributes to the involvement and participation of ethnic/racial minorities in research in that it is arguably more attractive to Blacks. Conducting interviews also gives the researcher an opportunity to explore the richness of the ethnic/racial minority experience and illuminate some of its nuances that as a method, quantitative analysis is not designed to capture. Particularly in health research, the qualitative approach provides more detailed information about the complex experience of health and nature of health behaviors (Stewart, et al., 2008).

One-time, In-depth, semi-structured interviews were conducted from the Summer of 2007 to the Summer of 2008 with 17 Black men and women aged 21-57 who had either been clinically or self-diagnosed with depression. In this study, I sought to speak with African American men and women who met the following criteria:

- Identified as Black or African American
- Was 18 years of age or older, and
- Answered yes to one or more of the following:
 - Has felt sad, empty or depressed for 2 weeks or more during their life
 - Has been told by a doctor, pastor, co-worker, family member or friend that they were depressed, or
 - Has seen a doctor, counselor or mental health professional for depression

Participants were recruited through flyers posted at local colleges and universities, libraries, area churches, social service agencies, doctors' offices and outpatient mental health organizations. Participants were recruited at two times: in the summer of 2007 and the summer of 2008. No compensation was offered during the summer 2007 recruitment period and included 8 college-educated and/or professional women. During the second recruitment period, 5 women and 4 men were recruited and completed interviews. These participants were given a \$10 gift card to a grocery or discount store for their participation.

Interviews were largely semi-structured and open-ended with some Likert-scale questions. *See Appendices for instruments.* They were conducted using an interview guide designed to have participants reflect on their experience(s) with depression including thoughts about the cultural messages they received

about depression and how these messages shaped their thoughts about the disorder and help-seeking. The Likert-scale questions were used to assess their personal endorsement of beliefs about depression and Black Americans as well as their perception about how Black Americans in general would respond to the beliefs. Interviews were conducted in locations of the respondents' choosing and included respondents' homes and local coffee shops. Interviews ranged from 30 minutes to 2 ½ hours. All participants' names were changed to maintain confidentiality.

All interviews were audio-recorded with the participants' permission using a digital recorder and transcribed verbatim. HyperResearch software was used to code and analyze the transcribed interviews and to detect relevant themes. A grounded theory approach was used to analyze the data. Grounded theory, a method developed by Glaser and Strauss is best defined as

a general methodology for developing theory that is grounded in the data systematically gathered and analyzed. Theory evolves during actual research, and it does this through continuous interplay between analysis and data collection (Strauss & Corbin, 1994, p. 273).

In other words, theory emerges from the data, not precedes it.

In this study, a crucial theoretical concept in understanding health behavior among Black Americans emerged: identity reconciliation. These interviews revealed that a key factor influencing health behavior is the negotiation of identity. Like many who struggle with mental disorders, these participants thought a great deal about who they were as a person with a mental health problems and how that new role/identity interacted with their other identities. For many of these participants, the impact of having a mental disorder often

conflicted with their racial/ethnic and gender identities. Most of these respondents had to go through a process of reflection and reconciliation of identities in order to better understand themselves, their disorder, and to maximize healing. Thus, the role of identity reconciliation becomes a key factor in understanding health behavior among Black Americans and should be included in our theoretical understanding of how people think about health, illness, and help-seeking.

Coding in this study was an iterative process. As the data was coded and subjected to “constant comparison,” codes were developed, rethought, reshaped, and redeveloped (Kelle, 2007). I began initially with line-by-line coding. This allowed me to stay close to the data and guided theme-development. I then moved to a more focused coding approach, using codes established earlier to move through the rest of the data more quickly and succinctly (Charmaz, 2006). This process also helped me rethink the relevancy and applicability of earlier codes and themes, reanalyzing data for new meaning. For example, as I began to code the interviews, it became clear that the language respondents used to describe their beliefs about depression, help-seeking and service use was highly racialized and often gendered. In other words, what it meant to be “depressed” was intertwined with what it mean to be “Black” and, particularly for some of the women in the study, what it meant to be a “Black woman.” The tension between these identities was not only key to the respondents’ illness narratives but also existed in a way that impacted help-seeking behavior in important ways. I realized that I needed to code for factors related to “identity” and “identity

reconciliation” if I was to capture the full meaning of these experiences. The remaining codes reflected emergent themes and sub-themes. In vivo codes, “participants’ special terms,” are used if and when relevant to help further theory development (Charmaz, 2006, p. 55).

Several themes, and sub-themes, emerged: the perception of a conflicting relationship between “Black” and “depressed” identities; the unique experience of stigma in Black communities; and culturally-shaped ideas about “help” for depression in Black communities. A chapter is dedicated to each of these broader themes and sub-themes are introduced.

Structure of the Dissertation

This dissertation is comprised of four additional chapters that examine various aspects of the depressive and help-seeking experience of Black Americans. Chapter 2 of the dissertation explores the beliefs held about what it means to be “Black” and “depressed.” Respondents discuss how these two identities interact and operate to prevent and/or delay entry into mental health treatment for depression. Chapter 3 focuses on respondents’ experiences with stigma and how beliefs about depression and individuals with depression are shaped and shared in Black communities. This chapter does not attempt to convey that being stigmatized is unique to Black Americans with mental health problems. Instead, it shows that the *experience* of stigma is unique for Black Americans in that they are a group that is already heavily marginalized, which makes adopting another stigmatizing identity particularly difficult for a number of

reasons. Chapter 4 of the dissertation discusses treatment for depression and respondents' beliefs about how Black Americans view help-seeking and mental health service use. Respondents not only discuss beliefs held in Black communities about treatment engagement but also share alternative methods for dealing with depression. All of these chapters illuminate the role culture plays in shaping health beliefs and behaviors around depression, help-seeking and service use. They hope to show that barriers to mental health service use extend beyond simple financial and structural factors and involve a web of factors that impact one's engagement in treatment.

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Chapter Two

Can You Be Black *and* Depressed?: Beliefs About Depression That Challenge Black Identity

“We pride ourselves in being strong, emotionally strong and able to bear a lot.”

Introduction

Depression is a major mood disorder that impacts the lives of many in the U. S. regardless of racial/ethnic background (Kessler, et al., 2005a, Williams, et al., 2007). While Black Americans have consistently been found to be less likely to meet the diagnostic criteria for major depressive disorder (MDD) than Whites (Blazer, et al., 1994; Kessler, et al., 2005a; Kessler, et al., 2005b; Williams, et al., 2007), the course of MDD among Blacks tends to be more severe and persistent (Williams, et al., 2007). Also, Black Americans have higher rates of unmet need for this disorder than do Whites (Redmond, Galea & Delva, 2009; USDHHS, 1999; USDHHS, 2001). For them, most of the diagnosable cases of MDD go untreated and tend to have more impairing effects (Wang, et al., 2005; Williams, et al., 2007).

Research has also shown that Black Americans utilize mental health services for depression and other mental health problems at a rate below that of Whites (Alegría, et al., 2008; Keyes, et al., 2008; Lasser, et al., 2002; Padgett,

Patrick, Burns, & Schlesinger, 1994; Sussman, Robins, & Earls, 1987; Williams, et al., 2007). There are a number of factors that can account for these persistent racial/ethnic differences in service utilization rates. Factors related to finances, insurance, ability to access services, appropriateness of services, and socio-cultural beliefs all have the potential to operate as barriers to treatment engagement (Ayalon & Alvidrez, 2007; Copeland, 2005; Cruz, et al., 2008; Ojeda & McGuire 2006; Snowden, 2001b; Thompson, Bazile, & Akbar, 2004). This article focuses on the impact of socio-cultural beliefs on treatment engagement and seeks to understand the role they play in the persistence of racial/ethnic disparities in mental health service use for depression. I use qualitative interviews with 17 Black Americans to explore how cultural messages about what it means to be “Black” can shape ideas about and behavior around depression, help-seeking and use of mental health services.

Barriers to Service Use

While lacking resources or access to care may prevent many Black Americans from accessing care, it is clearly not a barrier for all. Research has shown that even among employer-insured, non-poor Black Americans, rates of out-patient service utilization lag largely behind Whites (Ayalon & Young, 2005; Diala, et al., 2000; Kimerling & Baumrind, 2005; Padgett, Patrick, Burns, & Schlesinger, 1994; Snowden, 1999). This fact prompts researchers to view the topic of service use among Black Americans with mental health problems with a broader, more complex lens.

Some have looked beyond pure financial and structural factors to explain racial/ethnic disparities in service use and have placed a strong emphasis on more personal or psychological factors impacting one's access to care. An individual's personal awareness or views of mental disorders and treatment are a large factor in their decision to use mental health services (Anglin, Alberti, Link, & Phelan, 2008; Cruz, et al., 2008; Hines-Martin, Malone, Kim, & Brown-Piper, 2003; VanVoorhees, et al., 2005). Some individuals experiencing mental health issues may not think what they are feeling is problematic or might not recognize the symptoms they are experiencing as indicative of illness (Hines-Martin, Malone, Kim, & Brown-Piper, 2003; Thompson, Bazile, & Akbar, 2004; VanVoorhees, et al., 2005). Still others may not even think they have a problem or refuse to accept a diagnosis (Cruz, et al., 2008; Hines-Martin, Malone, Kim, & Brown-Piper, 2003; VanVoorhees, et al., 2005).

Other personal factors that may affect an individual's use of services for mental health problems are beliefs about how emotional distress should be addressed. While many may believe that symptoms related to mental distress require professional help, some Black Americans simply believe that the symptoms will go away or improve on their own (Anglin, Alberti, Link & Phelan, 2008). Many Black Americans also believe that they can, or should, deal with these kinds of problems on their own without outside intervention (Barksdale & Molock, 2008; Cruz, et al., 2008; Snowden, 2001b; Thompson, Bazile, & Akbar, 2004). Research has shown that Black Americans tend to believe that life is supposed to be difficult and may not view difficult experiences as a mental health

problem (Anderson, et al., 2006; Beauboeuf-Lafontant, 2007; Hines-Martin, Malone, Kim & Brown-Piper, 2003; Thompson, Bazile, & Akbar, 2004).

Scholars have also examined the importance of social factors that impact engagement in mental health treatment. For many, family is the "primary group that gives meaning to, provides interpretation for, and helps create a response repertoire for developing and maintaining certain behaviors," including health behaviors (Bagley, et al., 1995, p. 636). Therefore, Black families who support health behaviors such as seeking out professional help in times of distress can facilitate an ill individual's engagement in mental health treatment (Hines-Martin, Brown-Piper, Kim & Malone, 2003). Also, some Black Americans may engage in services because they believe that their familial relationships can be improved by addressing mental health problems (Schnittker, Pescosolido & Croghan, 2005).

While some of the aforementioned social factors aid in an individual's decision to seek and engage in mental health treatment, they can also be used to explain persistent racial/ethnic differences in service utilization rates. We know that families define and shape the social norms of their members. For many racial and ethnic minorities, seeking services may be viewed as being outside of the social norm (Barksdale & Molock, 2008; Cruz, et al., 2008; Snowden, 2001a). Black Americans in particular report fears of being viewed negatively by family members and friends if they seek professional help for mental health problems (Alvidrez, Snowden, & Kaiser, 2008; Ayalon & Alvidrez, 2007; Barksdale & Molock, 2008; Cruz, et al., 2008; Hines-Martin, Malone, Kim, Brown-Piper, 2003).

The Role of Culture

Facilitators and barriers to mental health service use, especially those that are personal and social in nature, are highly influenced by a factor that is often overlooked or simplified in discussions about racial/ethnic differences in the use of mental health services: culture. “Culture plays a [crucial] role in shaping beliefs, value and rule systems, problem-solving patterns, communication styles, and learned coping behaviors” (Matthews & Hughes, 2001, p. 77; Pedersen, 1986). Health behavior or how people think about, define and act toward illness as well as how they think about and approach health and healing is shaped heavily by culture (Angel & Thoits, 1987; Bagley, et al., 1995; Good, 1997; Kleinman, 1992; Kleinman, 1980a; Murray, 2001; Olafsdottir & Pescosolido, 2009). Moreover, conceptions of “health” and “illness” vary according to time, place and social context: culture determines what is considered normal behavior and what is considered symptomatic of an illness (Angel & Thoits, 1987; Capers 1991; Kleinman, 1988; Murray, 2001; Scheff, 1966). Culture also influences how people experience illness and how their distress is communicated (Angel & Thoits, 1987; Bagley, et al., 1995; Cole, Stevenson, & Rodgers, 2009; Good, 1997; Kleinman, 1988; Murray, 2001; So, Gilbert, & Romero, 2005).

Culture has been a “long abandoned topic” in scholarship (Small, Harding & Lamont, 2010, p. 6). With the popularization, and subsequent vilification of the “culture of poverty” doctrine introduced by Oscar Lewis in the 1960s, many scholars sought to distance themselves from a theory viewed as racist, ethnocentric, or at best, incomplete (Small, Harding & Lamont, 2010; Valentine,

1968). However, rather than challenging the theory, many researchers abandoned a crucial concept necessary for exploring differences between and within groups.

The use of the concept of culture in health research has its supporters and critics. As previously mentioned, because of the lingering legacy of the “culture of poverty” era, some view mere mention of culture as a means of explaining behavior or social conditions is viewed as victim blaming (Small, Harding & Lamont, 2010; Valentine, 1968). Still critics of an (over)emphasis on culture, particularly in health research, believe that scarce resources should be used to research and craft interventions that can be applied more universally (Fabrega, 1989). Those that support using culture believe that it is an important lens to better view and understand differences in health behavior (Angel & Thoits, 1987; Bagley, et al., 1995; Good, 1997; Kleinman, 1992; Kleinman, 1980a; Murray, 2001; Olafsdottir & Pescosolido, 2009).

Arguably, most scholars believe that the problem with culture is not its inclusion in research but its misuse. A number of researchers either employ outdated or narrow definitions of culture (Angel & Thoits, 1987; Lopez & Guarnaccia, 2000; Valentine, 1968). Too often particular beliefs, practices, and values are situated within a single ethnocultural group instead of viewed as expressions related to the beliefs and practices themselves, ones that the group just so happens to embody and employ (Lopez & Guarnaccia, 2000). Therefore, some behaviors and norms are erroneously ascribed to a group that may not truly reflect its inner-workings. It is this practice that made the “culture of poverty”

theory problematic (Valentine, 1968). Finally, some researchers over-emphasize differences *between groups* and under-emphasize *within* group differences.

While the use of culture in research has its problems in research, it still remains a key means to understanding how individuals from various racial/ethnic groups might think about depression and help-seeking, and thus, approach service use (Broman, 1987; Schnittker, Freese, & Powell, 2000; So, Gilbert, & Romero, 2005; Sussman, Robins, & Earls, 1987; Wittink, et al., 2009). It can offer a wealth of information to researchers and practitioners looking to improve service use rates for persons of color who feel they might benefit from such help.

Culture and Black Americans

Culturally, Black Americans have historically seen themselves as strong and have been thought of as resilient (Thompson, Bazile, & Akbar, 2004; USDHHS, 2001). Surviving and overcoming historical injustices and experiences of discrimination have been the basis for these feelings of cultural/racial pride, strength, and resilience. When people are ill, they may often feel weak or powerless against their illness. Can the feelings of weakness associated with suffering from a mental disorder interact with the feelings of strength linked with being a Black American?

The bulk of the research investigating the link between Black socio-cultural identity and mental health focuses on identity as a protective factor against mental health problems or the mediator of the relationship between other demographic characteristics and mental health problems (Banks & Kohn-Wood,

2007; Griffith, Neighbors, & Johnson, 2009; Richman, Kohn-Wood, & Williams, 2007; Sellers, Copeland-Linder, Martin, & Lewis, 2006; Settles, et al., 2010).

This research also focuses primarily on adolescents or emerging adults. Only a small body of research has examined the direct link between racial identity and help-seeking among adults, particularly mental health service utilization.

Redmond, Galea, & Delva (2009) found that individuals reporting stronger cultural identity are more likely to view their experiences in treatment with some providers as less helpful and less fulfilling.

While the body of literature is small, it illuminates the importance of focusing on the role of racial identity and the meaning of what it means to be “Black” play in help-seeking and service utilization among Black Americans experiencing mental health problems. Of course, the impact on help-seeking and use of services depends upon how strongly one embodies or identifies with these beliefs. Nevertheless, considering racial identity and the role of culture in treatment engagement among Blacks Americans is crucial to service use research. Focusing on racial identity and how it can operate as an impediment to service use might help explain the racial/ethnic differences in mental health service use that cannot be completely accounted for by finances and other strict issues of access.

Specific Study Aims

The current study was designed to better understand the racial/ethnic disparities in mental health service utilization rates by exploring the narratives of

Black Americans who have experienced depression. Through qualitative interviews, I sought to look beyond strict financial and structural barriers to care and learn more about how the socio-cultural beliefs Black Americans hold about what it means to be “Black” interact with ideas about what it means to be “depressed.” This study does not seek to extend blame or hold Black Americans responsible for their low rates of mental health service use for depression; it simply attempts to better understand how they think about depression, help-seeking and treatment in the hopes of informing interventions to increase service use.

Method

Sample/Study Participants

This study sought to speak with individuals 18 years of age or older who identified as Black or African American and responded “yes” to at least one of the following: 1) has felt sad, empty or depressed for 2 weeks or more during their life; 2) has been told by a doctor, pastor, co-worker, family member or friend that they were depressed; or 3) has seen a doctor, counselor or mental health professional for depression. A total of 17 Black American men and women were recruited using flyers posted at local colleges and universities, libraries, area churches, social service agencies, doctors’ offices and outpatient mental health organizations. The majority of the 17 participants were female (n=13). See *Table 2.1*. Participants’ ages ranged from 21 years of age to 57, with the majority of participants falling in the 22-29 and 40-49 age ranges. Nine

participants were diagnosed with major depression by a mental health professional, 3 were diagnosed by a medical physician, and 5 were self-diagnosed. Collectively, the study participants had achieved a high level of education with 5 completing or pursuing post-bachelor's education. Two participants were college graduates, 6 reported completing some college, 3 finished high school or received a GED, and one participant, the eldest in the study, did not graduate high school, finishing the 11th grade.

Interview Procedures

Participants were recruited during the summers of 2007 and 2008. Interviews were conducted in locations respondents' chose and included their homes and local coffee shops. The interviews were audio-recorded with the participants' permission and ranged from 30 minutes to 2 ½ hours. All participants' names were changed to maintain confidentiality.

Interviews were largely semi-structured and open-ended. See *Appendices for instruments*. They were conducted using an interview guide designed to have participants reflect on their experience(s) with depression, the cultural messages they received regarding depression and how those messages shaped their thoughts about depression and help-seeking. Participants were also asked about the opinions of a series of statements about depression and Black Americans. They were also asked to assess how Black Americans in general would respond to the same series of statements.

Analysis

The interviews were audio-recorded with the participants' permission and transcribed verbatim by the primary investigator, trained research assistant, or professional transcriptionist. Many of the "umms," "likes" and "you knows" were removed when appropriate to improve the clarity of the message. The primary investigator used HyperResearch software to code and analyze all of the transcribed interviews and to detect relevant themes. While the interviews yielded a wealth of information about Black Americans' experience with depression, I sought to uncover themes that emphasized the impact culture on how depression was viewed and how the idea of help and/or treatment was approached. For the purposes of this article, themes related to Black identity and its relationship to depression and treatment were highlighted.

Results

As respondents discussed their past experiences with depression, several themes emerged concerning beliefs they felt some Black Americans held about Black identity and how those beliefs often conflicted with what some believed it meant to be depressed. Several sub-themes also surfaced that helped place this more general theme into context.

Black People Are Strong and Can Deal With Anything

Perhaps the most pervasive theme to emerge from these interviews was

that Black Americans were a “strong people” who could deal with anything that came their way. Whether this was an idea they expressed themselves or one that they believed Black Americans at large would endorse, most of the respondents made some reference to the idea of “strength” being a definitive characteristic of being Black. Most references to strength were connected to the ability to deal with a great deal. It was an idea that Shalesa, a 35-year-old female, stated she had heard “so many times.” Margie, a woman in her late 40s, described it more as a kind of “folk wisdom,” “the kinda thing that, you know, when people are sittin’ around the table bull shittin’, that we all say, probably even me, you know.” The thought “even me” or the idea that respondents themselves believed that Black people can deal with anything that comes their way was shared by many respondents. While many personally agreed with this idea, a greater majority believed that Blacks in general would endorse the belief more strongly. See *Table 2.2*. One respondent, Margie, initially stated that she felt that Black Americans would “strongly agree” with the belief, and then changed her answer to “unsure/don’t know.” She stated that she found it “hard to generalize...for...many millions of people” and subsequently answered “unsure/don’t know” for all questions concerning the beliefs held by Blacks in general.

Respondents felt that an air of pride accompanied the belief that Blacks can deal with anything that comes their way. Margie says that she had heard this belief and that “the Black American community say that a lot with regard.” A 24-year-old female named Carol stated that as Black Americans, “we pride

ourselves in being strong, emotionally strong and able to bear a lot.” Some respondents believed this idea of strength is firmly rooted in the historical and social experience of Black Americans in this country. Denise, a woman in her mid-20s, stated that “[Blacks] feel like Black people are stronger than everybody else because Black people have been through so much.” Keith, a 55-year-old male, stated it differently. When supporting his belief that Black Americans at large would agree with the idea that Blacks can deal with anything, he said “I agree that they do. They deal with it. You know some of the comedians say, you know, they walk it off. And we’ve had to do it, you know? Collectively, we’ve had to do it.”

Kamille, a 26-year-old woman, had more to say about the historical legacy when asked to explain why she believed Black Americans experienced depression differently than other groups.

“I think like we have such a historical cultural legacy of overcoming and dealing with things and being able to get through that I think that contributes to the perception that Black folks don’t get depressed or even if you do, you just pray about it and God will take it away, and you just deal with it. Whereas I think that, for example, white people don’t have that same type of legacy. I don’t know, we always hear about celebrities going to like the hospital for like exhaustion and stuff. There’s this perception that you’re Black, you have to go and out and work, you know? You don’t have time to be going to the hospital talkin’ ‘bout you exhausted (laughs). You know, you just deal, and I think that’s a huge difference.”

Even those that did not link Black Americans' historical past to the theme of strength did talk about the about the difficulties of the Black historical experience. When discussing how Blacks are different from other groups

experiencing depression, Doris, the eldest respondent at 57 years old, believed that while depression does not discriminate, this country does: “Blacks are coming up from slavery, and we still have a lot of prejudiced people even today.” She also believed that “Blacks have been exposed to a lot more hardships.” Derrick, a clinically-diagnosed male in his late 40s to early 50s, also cited Blacks’ historical experience when explaining why he believed Blacks’ experience of depression was different than other groups:

Well because we had to fight, our backgrounds, our ancestors and where we came from and what we all had to go through. When you think about what Rosa Parks did that day on the bus, why does she have to sit in the back of the bus because of the color of her skin? That’s depressing. And just thinking about what she stood for at that moment and we as a people had to fight for to be where we are today, to me that weighs more on a scale versus let’s say a Caucasian race or Indians, the native Indians. You know what I’m saying? We had to fight more even though your particular situation or your particular family structure may be upper and you’re doing well and you might not have to fight for nothing and your dad might be governor, you know? It’s still there. Martin Luther King is still there. It’s real, you know?

Black People Don’t Get Depressed

Many respondents talked about what Kamille described as the “perception that Black folks don’t get depressed.” Sidney, a 28-year-old female, shared this sentiment stating that “some Black people believe that Black people can just dust their shoulders off and not get depressed and can deal with everything.” Janelle, another woman in her late 20s, expanded on this idea, saying

I think people would joke around, “oh, Black people don’t get depressed; they...” There was a saying. I can’t remember, but it was pretty much saying Black people don’t get depressed; they get over it or something to that effect, like it was non-existent in the Black community.”

This idea that depression is not something experienced by Blacks was shared by a number of respondents. Twenty-eight-year-old Elisa, stated that depression was a foreign topic within her family; rather, “white people talk about stuff like that.” In her experience, depression was not seen as a “Black person’s disease.” Kamille shared this experience, stating that for her, therapy was something “for white people.” For Laura, the youngest respondent at 21 years old, it was not even that depression was something experienced by others; it just did not exist. “At home, [she] kind of felt like there wasn’t any such thing as depression. It wasn’t real.”

Janelle and Kamille felt that the belief of a lack of depression among Black Americans was gender-specific and discussed depression in the context of being a Black woman. When talking about the messages she received about depression, Janelle said that for her, “the biggest thing was Black women are strong; they can handle anything.” Kamille talked about this perception in greater detail.

I think that there is a perception that Black women don’t get depression and that no matter what life throws at us, we just find a way to deal with it and overcome and pray and move on and then it’s over, which is a really oversimplified version of what happens. So, I think that there’s this perception that white women, they can cry and fall apart and they’re depressed and they take their medications and whatever, but Black women aren’t like that. (laughs) You know? We’ve been dealing with all kinds of adversities for generations. This a historical legacy that we just deal with it and move on, so I think that makes it hard to acknowledge the fact that you’re depressed when you are.

A couple of respondents talked about suicide among Black Americans and how it

is not recognized as something that threatens Black communities. Drucilla, another 49-year-old female, talked about how she believed that depression was a serious illness “cuz it could lead to suicide.” She went on to say that she knew individuals who completed suicide, “but they were white. It’s not too many Black Americans you find committing suicide.” On the other hand, Kamille noted the very real occurrence of suicide in Black communities but the failure of many to recognize it as a Black issue.

There’s a perception that Black people don’t commit suicide, like it’s not even an option, you know? So I think a lot of Black people are really shocked when (pause) There was, when I was in undergrad, a friend of a friend. They were co-workers. They were actually really close and one day... she was actually the last person to see this guy, Damien, alive. And you know the police came by her house one day and they’re asking her questions because they found his body and I remember we were just completely shocked that this 20 year old guy had killed himself. Completely shocked. And I remember telling my family about it and their first thing was like, “oh, I know he wasn’t Black.” (laughs) I was like, “umm, yeah actually he was Black.” And they were like, “oh, my gosh,” like that just doesn’t happen in a Black community.

While all of the respondents believed in the existence of depression in Black communities and disagreed with the belief that Black people do not get depressed, their feelings about how Blacks in general felt about this belief varied greatly. See *Table 2.2*. Two respondents believed that Black Americans in general would strongly agree with the statement that Black people do not get depressed. Five believed they would agree. Three respondents were unsure how Blacks in general would respond while three and four respondents believed that Blacks would disagree and strongly disagree, respectively. Some respondents discussed the feelings underneath their responses. Elisa stated

that distress in Black communities is “not seen as depression” and that “feel[ing] bad all the time” is “just how life is.” She went on to say that there is an assumption that “people get depressed but you just suck it up. You deal with it.” This idea that “you deal with it” is related to what respondents said when talking about the concept of strength. The belief that Blacks are strong and able to deal with anything that comes their way closely mirrors ideas that when distressed they deal with it, seemingly effectively. Sidney, Keith and Kamille, all quoted earlier, made statements about the ability to deal with the difficulties of life by “dust[ing] your shoulders off” (Sidney), “walk[ing] it off” (Keith) or simply “just deal[ing] with it” (Kamille).

Also, mirroring the concept of strength is the link to the historical past and the idea that life was supposed to be hard but also successfully endured. Elisa believes that based on “the context that Black Americans have had in this country, you just had to struggle and suck it up. Depressed or not, you had to suck it up and cope the best way you could.” Elisa said more about this “context,” stating

Well, I could always pull out slavery for one, but just... you know, discrimination, racism, poverty, economic strife, educational inequality, violence. I mean, these are all real reasons to be sad regardless if you're not predisposed to be depressed or not. So we've had to learn to cope with sadness whereas I think with my white and Asian friends, they didn't have to cope with that in the same way.

Impact of These Beliefs on Black American Depression Sufferers

Respondents commented on the impact these socially- and culturally-

influenced beliefs around strength and pride had on those who may be depressed and distressed. Some respondents expressed how these beliefs made it personally difficult for them to identify depression or recognize their symptoms as problematic. Kamille said that she “didn’t even recognize [her] symptoms as depression...simply because [she] thought that...Black people just don’t get depressed.” Kamille went on to say

I think I would be more willing to recognize a weepy white woman as being depressed versus a Black woman who did the same thing. I think there’s almost a stereotype that that’s how white people are, that they haven’t had any hardships, so of course, they’re gonna fall apart at the slightest provocation. I think I just thought that Black people just weren’t...we just weren’t built that way, so-to-speak.”

Elisa stated how she “didn’t think [depression] was an illness or anything until [she] got to be 19 and got out of [her] house and was around a bunch of white people (laughs).” She said that it was not until that time that she was “like ahh, wait! This isn’t normal.”

Other respondents cited the concept of strength and regard of a historical past that made it difficult for them to admit to being depressed. Richard, a male aged 39, stated that the idea that “we are strong and when you are strong you can get over anything” made him reluctant to share his struggles with others for fear of appearing weak. He also stated that the historically and culturally-infused concept of strength kept him from seeking help:

Because we have been through so much physically, it’ll make you think that you don’t need help. You are going to get over it one day; you just need the strength, you know?

Laura shared this sentiment stating

I think because Black Americans have gone through so much as a race and have been through so many hard things that being depressed for what seems like no reason isn't something you can really admit to.

Janelle agreed:

Blacks will have [depression] but not acknowledge it or they'll deny it, especially Black women cause it's always "oh, you're the matriarch, you have to be the strong one" and you know, it's kinda like you're not allowed to be depressed, almost.

While there is understandably a great deal of pride surrounding the strength of a people who could endure being enslaved and the vestiges of slavery called racism and discrimination, many respondents took issue with the belief that often accompanies this sense of strength and pride: the apparent ability to deal with just about anything.

I think there is a perception that we can deal with anything without any trouble, and that if we keep working at it then things will get better. But I honestly think that there is some things that happen...or maybe it's not even one single thing, it's a series of things...any one person should not be expected to just be able to deal with it on their own. - Kamille

Even those who accepted the idea that life was expected to be difficult did not believe you simply "deal with" those feelings. Elisa stated that when "considering the context in which we've had in this country, I think that's reasonable to assume" that feeling bad is a part of life. However, she believes that it is "totally unreasonable to assume that sometimes you feel bad, you're sad and...that you just deal with it." Keith, who was quoted earlier discussing the ability of Blacks to "walk it off," quickly followed this statement saying that he did

not mean to say that this was “always positive.” Like Elisa and Keith, other respondents doubted the ability of anyone, including Blacks, to simply “deal with” struggles like depression. Margie stated that

It is frequently interpreted...that I don't need help, I can deal with anything that comes my way, and I not only strongly disagree with that for Black people, I strongly disagree with that for human beings in general.

Shalesa said it more plainly: “I don't think anyone can deal with anything that comes their way.” She went on to say that “that whole image of the strong Black woman or the strong Black man can do more damage than good. It's not like Black people are invincible. No one is.”

The idea that these beliefs can cause more harm than good was shared even by those who believed in the strength of Black people to get through many things. They, too, recognized that the severity of problems experienced should be assessed. Sidney felt that “Black people for the most part, and [her]self, in general could get through anything, but she quickly added that “times are hard,” going on to say that we do not know “how extreme” things are for people and that some “may want to commit suicide.”

Two respondents discussed the lack of reflection on beliefs like “life sucks” and the ability to “suck it up and just deal with it.” Elisa observed that people come to accept that people feel bad and that life sucks without “realizing how it's affected how they look at life.” Kamille also considered the acceptance of these beliefs and the toll it takes on Black Americans' mental health, many times unbeknownst to them.

I think it's really important that as Black people, we really stop and assess the emotional toll that things have on our lives. I think a lot of times we just sort of just suck it up and just deal with it without recognizing the emotional, the spiritual, the psychological toll that things can have on us. I mean, I think there's just been very bad situations that I've been in that I just thought that, I just have the strength to just deal with it and make it through without really assessing the emotional toll it was having on me.

Discussion

The Impact of Culture

This study sought to better understand the service use behavior of Black Americans with depression by exploring the beliefs Black Americans hold about depression, help-seeking and treatment. Equally important in this study was to examine how these messages were shaped by culture. The results of this study shed more light on the socio-cultural experience of Black Americans who have experienced depression and the messages they received about what it means to be “Black” and “depressed”.

Many of the beliefs respondents identified and discussed stemmed from the seemingly synonymous nature of being “Black” and the concept of “strength.” It was this relationship between Black identities and being strong that made depression seem non-existent in Black communities and contributed to the racialized views of depression and treatment. Many respondents described the difficulty in trying to acknowledge and deal with their depressions in communities that, for socio-cultural and historical reasons, viewed depression undermining the image of Black strength.

The ability to “deal with anything” accompanied beliefs about strength, a

sentiment expressed in previous research (Beauboeuf-Lafontant, 2007; Thompson, Bazile, & Akbar, 2004; USDHHS, 2001). Two out of the 17 respondents believed that Blacks in general would not endorse the belief that Black people can deal with anything that comes their way. Only 3 respondents did not support this idea for themselves. The fact that respondents' feelings on this belief were more closely aligned with that of Blacks in general was surprising given that respondents tended to distinguish themselves from Blacks in general by taking stronger stances against negative ideas about individuals with depression or the inability of Black Americans to be depressed. This finding shows that cultural pride surrounding the ability of Black Americans as a people to overcome adversity and struggles persist even though respondents believed that Black Americans were not "invincible" to life's difficulties.

Consistent with previous research, this study finds that strength and ability to deal with adversity of many kinds is tied to the historical and social experiences of Blacks in the U.S. (Beauboeuf-Lafontant, 2007; USDHHS, 2001). Many respondents felt that the message in the community was clear: if Black Americans could endure the brutality of slavery and the injustice of racism and discrimination, they could and should be able to deal with anything. These beliefs often undergirded the depiction of Black men and women as the pillar of strength described by respondents.

The idea that life was expected to be difficult and Black Americans were built to respond was also expressed by respondents and supported by previous research showing that many Black Americans believe that hard times and

adversity are a part of life and that they are expected to show strength in order to get through them (Anderson, et al., 2006; Beauboeuf-Lafontant, 2007; Hines-Martin, et al., 2003; Thompson, Bazile, & Akbar, 2004). Some respondents echoed these sentiments stating that “feel[ing] bad all the time” was “not seen as depression” and instead, was “just how life is.” It was the respondents’ perception that Black Americans were to follow the lead of their ancestors and “dust your shoulders off,” “walk it off,” simply “just deal with it.”

More respondents expressed stronger criticism of the idea that Black people do not get depressed. All of the respondents interviewed disagreed, 12 strongly, with this belief. Only 7 respondents believed Blacks in general would disagree with it. Further, respondents described an environment where depression was viewed as non-existent or not real in Black communities. For some respondents, it was not until they left their familial homes or were exposed to people of other races that they begin to realize that depression was a real problem for them. These statements highlight the absence of important conversations about mental health in Black communities and the belief that depression and treatment were things for “white people.” Again infused in these beliefs were ideas related to strength and the ability to handle adversity due to Blacks’ historical and social past. According to respondents, many Black Americans believed that it was because people from other races lacked this past that they were unable to deal with things and thus became depressed and needed treatment.

Respondents believed that it was ideas like these that delayed their own entry into services and currently keeps many Black Americans who need help from seeking it. They felt that the ability of their ancestors to overcome adversity is viewed too narrowly and thus, remembered too simply. While they believed that it was no doubt admirable and a source of great pride that Black Americans survived many historical and social atrocities, some respondents felt that the failure to recognize the “emotional, the spiritual, the psychological toll that things can have on us” makes the cry to “dust your shoulders off” an uninformed and potentially dangerous practice.

Limitations and Future Directions

The most important limitation of this study was that the sample was non-representative. Having a more representative group of participants would have given this study more insight into the diverse depression experiences of Black Americans and their feelings about the relationship between Black identity and help-seeking behaviors for depression. While the majority of study participants were diagnosed with depression by a mental health or medical professional, another limitation of this study is that data was collected from participants who were allowed to self-identify as depressed. The idea here was to capture Black Americans who experience depression but who had not been formally diagnosed; arguably, the bulk of depressed Blacks are those who have had no interaction with mental health professionals and/or services. While the recruitment flyer used language that mental health professionals themselves use

to define an episode of depression (feeling sad, empty or depressed for a period of 2 weeks or more during their lifetime), without a proper diagnosis, we are not sure if those who were “self-diagnosed” actually met the criteria for major depression.

The limitations of this study not only illuminate areas of concern but also highlight directions for future research. By increasing and diversifying the sample, we can increase the number of men in the study as well as capture a sample more reflective of the Black population at large. Also, with a larger, more diverse sample, we can look more closely at within-group variations in the beliefs held about Black identity and depression. Future research should also extend beyond talking to depression sufferers themselves and can include actual laypersons’ beliefs about depression and help-seeking. While it is important to understand the perceptions those diagnosed with depression have about Black Americans’ views about depression and treatment, it is equally important to assess the actual community climate about depression and treatment by talking to those who in the community who have not experienced depression. These climate-assessment studies can also be replicated to examine the “temperature” within families and in mental health care settings.

While this study was not without its limitations, it was novel in its focus on the role of identity and the process of identity-reconciliation in how Black Americans understand depression and think about help. It showed how beliefs around being “Black” and “depressed” impacted how respondents thought about themselves and treatment. It also revealed how many respondents went through

a process of identity-reconciliation where they came to terms with conflicts between their numerous identities in a way that removed barriers to seeking treatment for their depression. More research should focus on how identities around race, ethnicity, and gender interact with those around illness, as well as the process of identity-reconciliation and its role in facilitating treatment engagement. This course of study will help us better understand health behavior and help-seeking patterns among Black Americans.

Conclusion

While Black Americans have some of the lowest incidence of major depression, they also carry the heaviest burden of the disorder. Their symptoms tend to be more severe and the course of illness more persistent. They also utilize services for depression and other mental health problems at a rate far lower than that of their white counterparts. It is important that research continues to take a more culturally-focused approach to better understanding Black Americans' ideas about depression, help-seeking, and treatment with the goal of informing the design and implementation of interventions aimed at improving mental health service use rates among those who feel they may benefit from services. This approach to research and dissemination of knowledge will also help destigmatize depression and treatment as well as redefine the concept of "strength," helping shift understanding of depression, treatment and what it means to be Black with a mental health problem.

Table 2.1 - Characteristics of Sample (n=17)

Variable	Number	Percentage
Gender		
Female	13	76%
Male	4	24%
Age		
18-21	1	6%
22-29	6	35%
30-39	3	18%
40-49	5	29%
50-59	2	12%
Education		
Some High School	1	6%
High School/GED	3	18%
Some College	6	35%
College Graduate	2	12%
Post-Graduate	5	29%
Diagnosis		
Self	5	29%
Psychiatrist	4	24%
Therapist	3	18%
Mental Health Professional (Type Unknown)	2	12%
Medical Doctor	3	18%

Table 2.2 – Endorsement of Beliefs Related to Being Black (n=17)

Belief	Self	Blacks In General
Black people can deal with anything that comes their way.		
Strongly Agree	n = 1	n = 6
Agree	n = 7	n = 6
Unsure/Don't Know	n = 6	n = 3
Disagree	n = 1	n = 1
Strongly Disagree	n = 2	n = 1
Black people do not get depressed.		
Strongly Agree	n = 0	n = 2
Agree	n = 0	n = 5
Unsure/Don't Know	n = 0	n = 3
Disagree	n = 5	n = 3
Strongly Disagree	n = 12	n = 4

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Chapter Three

The Stigma of Depression: The Black American Experience

“Not only in the general populace is there a stigma, but it’s there in our community on a very strong level.”

Introduction

Individuals with identities not considered “normal” in society often experience stigma. Stigma can be defined simply as “an attribute that is deeply discrediting” (Goffman, 1963, p. 3). It is a characteristic, behavior, identity, anything that is seen as “incongruous with our stereotype of what a given type of individual should be” (Goffman, 1963, p. 3). Stigmatizing behavior from others can take many forms, including social distancing and discrimination. Individuals may also experience a reduction or loss of social status (Link & Phelan, 2001).

A stigmatized person may respond to being set apart in a number of ways, none of which are necessarily mutually exclusive. Some individuals may see the thing that sets them apart from what is “normal,” as “a defiling thing to possess,” the outgrowth of which can be shame (Goffman, 1963, p. 7). Others may “handle the risks by dividing the world into a large group to whom he tells nothing, and a small group to whom he tells all and whose help he then relies” (Goffman, 1963, p. 95). Still others may avoid potential stigmatizers altogether (Link & Phelan, 2001).

Stigma is a problem common to many who have suffered from mental illnesses. In many ways, it can exacerbate their distress (Yang, et al, 2007). While this experience of stigma is universal, the impact and implications can be different, and arguably worse, for racial/ethnic minorities (Bailey, Blackmon, & Stevens, 2009; Givens, et al., 2007; Mishra, et al., 2009; USDHHS, 2001). Historically, people of color have been stigmatized and marginalized because of their racial and/or ethnic identity. Adding another stigmatizing identity in the form of a mental illness can have serious repercussions for people of color (Bolden & Wicks, 2005; Conner, et al, 2010b; Gary, 2005; Matthews, Corrigan, Smith, & Aranda, 2006).

While depression and stigma have been investigated a great deal, research focusing on the stigma experienced by Black depression sufferers is sparse by comparison. This study seeks to address this gap in the literature through interviews with 17 Black American men and women about their experiences with depression and the stigma they may have experienced. Through these interviews, we not only understand more about how stigma can operate as a barrier for those seeking help for depression but we also learn more about how stigma is understood, experienced, and combated in Black communities.

Stigma in Black communities

Perhaps one of the largest social barriers studied in mental health service use research is stigma. Actual experiences or the fear of being stigmatized keep

a large number of people who might benefit from treatment out of services (Anglin, Link & Phelan, 2006; Corrigan, 2004; USDHHS, 1999). While stigma is a large barrier for all racial/ethnic groups, research has found that stigma is more of a factor in the illness and treatment experience of Black Americans than it is for many other racial/ethnic groups (Anglin, Link, & Phelan, 2006; Bailey, Blackmon, & Stevens, 2009; Carpenter-Song, et al., 2010; Conner, et al., 2010a; Cruz, et al., 2008; Matthews, Corrigan, Smith & Aranda, 2006; Rusch, Kanter, Manos, & Weeks, 2008), and in some cases, more so for Black women than men (Menke & Flynn, 2009). Some Black Americans have discussed the existence of social proscriptions to keep matters private and not to discuss their struggles with others (Conner, et al., 2010b; Carpenter-Song, et al., 2010). Others believe that they will be treated negatively, discriminated against or socially excluded if others find out about their mental health problems (Bailey, et al., 2011, Carpenter-Song, et al., 2010; Mishra, et al., 2009). Regardless of the type experienced or feared, stigma stops a large number of Black Americans from seeking treatment.

Many Black Americans feel that the stigma attached to mental illness is felt more strongly in Black communities (Bailey, Blackmon, & Stevens, 2009; Conner, et al, 2010b; Moran, et al., 2004). Those whose illnesses are known have reported experiencing stigmatizing attitudes and behaviors from people in their communities (Conner, et al., 2010c). Many whose illnesses are unknown to others have expressed reluctance to reveal that they have mental disorders for fear that they will be subjected to ridicule and rejection (Bailey, et al., 2011; Carpenter-Song, et al., 2010; Mishra, et al., 2009). A desire to avoid being

labeled as “crazy” or subjected to social exclusion can cause some to hide their illnesses and/or the fact that they seek treatment (Conner, et al., 2010c; Matthews, Corrigan, Smith & Aranda, 2006; Mishra, et al., 2009; Roberts, et al., 2008). For others, it may cause them to delay seeking services or avoid treatment altogether (Alvidrez, Snowden & Kaiser, 2008; Calloway, 2006; Jackson, 2006; Mishra, et al., 2009).

Some believe that stigma is stronger in Black communities because individuals simply lack information about mental disorders and treatment (Conner, et al., 2010b). However, even after interventions to educate Black Americans about mental illness and reduce stigma, stigmatizing views continued to be held and in some cases were strengthened (Rao, Feinglass, & Corrigan, 2007). The precarious social status of Black Americans in the U.S. may contribute to stronger stigmatizing attitudes and behaviors in Black communities. Problems with mental illness are viewed as “reduc[ing] one’s social standing and life opportunities” (Matthews, Corrigan, Smith & Aranda, 2006, p. 262). For groups like Black Americans who occupy statuses that have historically pushed them to the margins of many social spaces, adopting another potentially stigmatizing identity is not something done easily as it can come with serious threats to one’s status (Bolden & Wicks, 2005; Conner, et al, 2010b; Gary, 2005; Matthews, Corrigan, Smith & Aranda, 2006; Mishra, et al., 2009). Some research has found that African Americans more than Latinos or Whites desire more physical and social distance from those with mental illness (Rao, Feinglass, & Corrigan, 2007). It may be that Black Americans who do not suffer from

mental illnesses fear losing their tenuous status because they are associated with someone who is ill (Abdullah & Brown, 2011; Rao, Feinglass, & Corrigan, 2007).

The fear of being found guilty by association can also produce stigmatizing attitudes and behaviors from family members of those diagnosed with mental disorders. Many Black Americans suffering from mental illnesses have expressed fears of experiencing stigmatizing attitudes or social exclusion from family and friends when experiencing a mental health problem (Alverson, et al., 2007; Alvidrez, 1999; Alvidrez, Snowden & Kaiser, 2008; Connor, et al., 2010c; Cruz, et al., 2008; Roberts, et al., 2008). However, this is not the experience of all. For some Black Americans, having a serious mental illness did not bring familial exclusion (Carpenter-Song, et al., 2010). In their study of ethno-cultural variations in the experience and meaning of mental illness, Carpenter-Song, et al. (2010) found that Blacks were the least likely of the racial/ethnic groups studied to feel that their family would be disappointed in them because of their illness.

Not all research on mental illness and stigma among Black Americans find stigma to be a barrier to service use. While stating that Blacks *could* hold more stigmatizing views of those with mental illnesses, Abdullah & Brown (2011) also admitted that Blacks may in fact respond to those with mental illness more sympathetically due to their socially collectivist spirit. In another study with 185 African American women, Ward & Heidrich (2009) found that these women reported they would not only be comfortable speaking to a mental health

professional if they experienced problems but would not be embarrassed if their friends knew about it. However, this study did not specifically sample women who had experienced mental health problems. Moreover, respondents were interviewed about a hypothetical situation that, according to previous research, some Black Americans did not believe they would encounter (Waite & Killian, 2008).

Even if studies of stigma were less divergent in their findings, the very study of stigma would still be a difficult undertaking. Stigma is a complex social phenomenon with a number of factors that determine how it operates (Rusch, Kanter, Manos, & Weeks, 2008). Some research has found that levels of stigma may be linked to the severity of symptoms experienced (Rusch, Kanter, Manos, & Weeks, 2008). According to Rusch, Kanter, Manos, & Weeks (2008), the fact that Black Americans held more stigmatizing views was due to experiencing more severe symptoms, not simply their race or ethnicity. The study of stigma is also further complicated by the fact that stigma can be internalized and experienced personally as well as publically (Brown, et al., 2010; Corrigan, 2004; Conner, et al., 2010b; Rusch, Kanter, Manos, & Weeks, 2008). For instance, when Black Americans talk about stigma, it can be difficult to tease out what they feel personally and what they believe the community feels (Mishra, et al., 2009). In one study that did examine internalized and public stigma, Brown, et al., (2010) found that internalized stigma, not public stigma impacts attitudes about mental health services among Blacks.

Specific Study Aims

Most of the research on stigma and mental illness focuses on mental illness in general or on illnesses other than depression. A small subset of that research examines the experiences of Black Americans, and only a few of those have examined depression and stigma (Brown, et al., 2010; Conner, et al., 2010a; Conner, et al., 2010b; Conner, et al., 2010c; Givens, et al, 2007; Menke & Flynn, 2009; Rusch, Kanter, Manos, & Weeks, 2008). The current study sought to add to this body of research and was designed to investigate the stigma attached to depression and mental health service use among Black Americans. Through qualitative interviews, this study explored Black Americans' experiences with depression, including experiences of stigma in Black communities. Although I highlight the experiences of stigma among Black depression sufferers, I do not argue that stigma itself is unique to Black Americans who are depressed. Rather, I seek to show that the stigma Blacks encounter and experience is unique. It is important to recognize and understand these differences when designing and implementing interventions targeting Black Americans.

Method

Sample/Study Participants

This study sought to speak with individuals 18 years of age or older who identified as Black or African American and responded “yes” to at least one of the following: 1) has felt sad, empty or depressed for 2 weeks or more during their life; 2) has been told by a doctor, pastor, co-worker, family member or friend that

they were depressed; or 3) has seen a doctor, counselor or mental health professional for depression. A total of 17 Black American men and women were recruited using flyers posted at local colleges and universities, libraries, area churches, social service agencies, doctors' offices and outpatient mental health organizations. The majority of the 17 participants were female (n=13). See *Table 3.1*. Participants' ages ranged from 21 years of age to 57, with the majority of participants falling in the 22-29 and 40-49 age ranges. Nine participants were diagnosed with major depression by a mental health professional, 3 were diagnosed by a medical physician, and 5 were self-diagnosed. Collectively, the study participants had achieved a high level of education with 5 completing or pursuing post-bachelor's education. Two participants were college graduates, 6 reported completing some college, 3 finished high school or received a GED, and one participant, the eldest in the study, did not graduate high school, finishing the 11th grade.

Interview Procedures

Participants were recruited during the summers of 2007 and 2008. Interviews were conducted in locations of the respondents' choosing and included respondents' homes and local coffee shops. The interviews were audio-recorded with the participants' permission and ranged from 30 minutes to 2 ½ hours. All participants' names were changed to maintain confidentiality.

Interviews were largely semi-structured and open-ended. See *Appendices for instruments*. They were conducted using an interview guide

designed to have participants reflect on their experience(s) with depression, the cultural messages they received regarding depression and how those messages shaped their thoughts about depression and help-seeking. Participants were also asked about the opinions of a series of statements about depression and Black Americans. They were also asked to assess how Black Americans in general would respond to the same series of statements.

Analysis

The interviews were audio-recorded with the participants' permission and transcribed verbatim by the primary investigator, trained research assistant, or professional transcriptionist. Many of the "umms," "likes" and "you knows" were removed when appropriate to improve the clarity of the message. The primary investigator used HyperResearch software to code and analyze all of the transcribed interviews and to detect relevant themes. While the interviews conducted yielded a wealth of information about Black Americans' experience with depression, in this part of the study, I wanted to focus on the topic of stigma by exploring how respondents talked about depression and depression sufferers, the stigma they encountered/experienced, and how culture shaped these conversations.

Results

Respondents were asked about their experiences of depression and themes related to the social environment surrounding Black Americans with

depression were highlighted. One of the strongest of those themes was stigma. Characterizations of depressed individuals, race/culture-specific aspects of dealing with depression, and the impact of the diagnosis on the social interaction of sufferers emerged from the conversations with study participants.

Characterizations of Depressed Individuals

Several ideas about the beliefs people carry about depressed individuals were brought up in the interviews.

“Crazy”

The idea that depressed people were perceived as “crazy” was mentioned frequently by many respondents. Keith felt that there were “a lot of...old stereotypes...still here and living large” about people with depression. When asked to describe those stereotypes, he replied “just that one word: ‘crazy.’” Keith said later that it is the “label” one receives from those who are “not educated” about the illness. Sidney agreed, saying “people may be like ‘oh, she’s crazy’ or whatever and not fully understand what it’s all about if they’re not educated too well on that subject.” Elisa felt that the characterization of individuals with depression as “crazy” comes from a tendency to view depression far too simply. She did not believe that “Black people see depression as a spectrum,” but rather that “either you’re not depressed or you’re like one of those crazy depressive people who are in the hospital.”

While Keith and Sidney felt that individuals using that moniker were people who had not experienced depression, Drucilla believed that the characterization is used even by those experiencing problems. She said that when recommending to others ways to address their feelings “if [she] would say ‘well go see a counselor for depression,’ they might not want to do that, you know? They say “oh, I ain’t crazy. I don’t want to go see a shrink.” Denise also believed that people link counseling with being “crazy,” stating

I mean, people think that people who go to therapy are crazy, you know? So....it’s a societal judgment and people think that it’s....I mean, I think a lot of people think there’s something really wrong with people who are depressed, and it’s not...it’s so stigmatized and it shouldn’t be.

Some respondents felt that these ideas of being viewed as “crazy” were intertwined with those about race. Janelle described the response of some Blacks to other Blacks with depression as “oh, you’re crazy like those White people.” Keith implied that there were some characterizations that, as a Black man, he could handle, but others were harder to tolerate: “I can stand the label of being an angry Black man, but I don’t think I want to deal with being an angry, crazy Black man, you know?”

“Weak”

Another belief respondents believed others held about individuals with depression is that they were weak. Derrick stated that “society looks down on weakness.” It was this perception that some respondents believed fueled their reluctance to tell others that they were feeling depressed. When discussing why

he did not discuss his depression with others, Richard said that people would think “you’re weak if you tell them something like that.” He also believed it kept Blacks at large from seeking help for depression, stating “I mean they don’t even want to go to a doctor. (laughter) The stigma again. They think you are weak or, you know, different...”

Sidney also described how beliefs held about people with depression affected her:

Well, just that you don’t necessarily want to be seen as a weak person, I guess. So you may not be so open to just be telling people that unless they’re, you know, your close friends or family members.

Richard agreed, saying that often times, people with depression “don’t want people outside the family to know.” While some respondents stated that depression could be discussed with family and close friends, others shared that even conversations with family members and friends could prove difficult because of the stigma of being perceived as weak. When listing people she would not tell about her depression, Shalesa said that she would not discuss it with her father-in-law because “he would definitely perceive it [break] he would definitely perceive it as a weakness.”

Like “crazy,” respondents believed that weakness was a characterization entangled with race and sometimes gender. Most of the respondents commented that Blacks generally viewed individuals with depression as weak. See *Table 3.2*. Many of these ideas about weakness were expressed as beliefs about appearing strong or able to deal with things. Carol “believe[d] that [Black

Americans] pride [them]selves in being strong, emotionally strong and able to bear a lot.” Denise shared this sentiment, stating that she felt Blacks in general “feel like Black people are stronger than everybody else” and “if we have a problem in our life that’s upsetting us, we should be able to deal with that.”

When looking at the intersection of race and gender, Shalesa believes that there is an “image of the strong Black woman or the strong Black man” that many Black Americans feel they must emulate. Janelle feels that it is this image that forces some people to “deny” or “not acknowledge” the fact they are depressed, “especially Black women.” She went on to say that it is “cause it’s always ‘oh, you’re the matriarch, you have to be the strong one’ and you know, it’s kinda like you’re not allowed to be depressed almost.” Kamille felt that her “image of what depression is” was shaped by the cultural messages she received about depression. She said that it wasn’t until later that she came to understand that depression affected many and the image was not simply “White women who can’t deal with life.” Keith had this to say when describing his depression:

I don’t know if you asked...another manifestation of the depression is tears. I’d be just driving, you know, and then all of a sudden I’m crying. I don’t know if it’s a song on the radio, but the tears, you know? I’m just...I’m thinking about this or that, and for an African American male to do that in public, you feel very vulnerable, you know? It’s a sign of weakness. You know, it’s like an Achilles heel. And especially if you came up in the streets, that’s something you never want to do because, you know, it’s like that little triple wildebeest: you don’t stand a chance. (laughs)

Stigma in Black Communities

While the stigma attached to mental illness is not unique to Black

Americans, some respondents felt that their experiences were indeed different from those of other races. Some respondents stated that stigma was stronger in Black communities. Richard observed that “not only in the general populace is there a stigma, but it’s there in our community on a very strong level.” Other respondents also shared this belief. Denise stated that depression and treatment were “even more stigmatized in the Black community than in any other community” and that “you’re more likely to encounter people who don’t understand.” She stated that it was this perception that made “Black people...less inclined to actually wanna tell other people and wanna actually seek professional help.” Sidney agreed, saying that she found it “more with Black people” that “they don’t feel maybe as comfortable showing it or telling other people or as open about it.”

The idea that Black communities held less accepting ideas about depression and service use was shared by other respondents. Kamille stated

Like the core of people that I socially interact with are Black. I think that would’ve made me less likely to come and be like, “hey, guess what? I’m depressed.” So, I think that made me even more hesitant to broach the subject or to really talk about the real deal about how I was feeling.

Laura stated that she believed “for Caucasians, in general, [depression] is more accepted.” Elisa agreed, stating that the White community was more “progressive” and “more understanding about mental disorders.” So, she “was more likely to tell White people than Black people (laughs).” She went on to note that

[Whites] would be understanding and sympathetic towards it, and they

would listen to me and not tell me, “oh you should just do this....” or “you should get over it” and things like that cause I feel like that’s how a lot of my family members reacted to my mom when she talked about her depression, so.....

Respondents also described a cultural environment in which depression and treatment were not only stigmatized but that there were proscriptions about discussing the topic. Laura stated that it was this perception that “made the whole coming out as depressed more difficult.” She said that depression “isn’t really a widely talked about issue in the African American community” and that “it was pretty taboo within the African American community itself.” Other respondents also used the term “taboo” to describe why they and other Black Americans found it difficult to talk about or seek help for their depressed feelings:

It just goes back to it being such a taboo subject in the Black community.
I think that’s the biggest thing – Janelle

It’s still a taboo thing – Miller

I think it’s extremely taboo to talk about suicide, or like there’s a perception that Black people don’t commit suicide, like it’s not even an option, you know?- Kamille

Some respondents expressed the belief that depression was not so much of a taboo topic as it was a private one. When discussing the differences between the way Black Americans and members of other racial/ethnic groups experience depression, Shalesa stated that “often times in the African American community, there’s more reluctance to acknowledge that depression is an illness.” She went on to explain that there may be “more secrecy,” that “maybe other African Americans think it should be kind of a private thing, you know?”

Kind of like not airing dirty laundry.” Drucilla alluded to this sentiment when she said that she felt other Black Americans may not agree with “how [she chose] to cope with [depression] - talking to someone about the situation.”

Sometimes the private or taboo nature of depression and treatment can create feelings of shame in those who are depressed. Shalesa believed that her father-in-law’s negative views about individuals with depression came from his own “shame” around taking anti-depressants. Laura felt that the shame had racial implications:

I think with Caucasians, like I said earlier, it’s easier for them to say...to admit that they’re depressed, but for African Americans, there’s more of a sense of a struggle within the community and to be depressed for what seems like no reason seems almost shameful.

This shame can be evidence of internalizing the stigma attached to being depressed and seeking treatment. While a large majority of the respondents did not endorse the belief that depressed people were weak, a few did identify weakness as a characterization/stigma that they internalized. By their own admission, Shalesa and Margie believed they were weak because of their depression. When Shalesa was asked about how she felt about the statement that individuals with depression were weak, she stated “I know, I’m supposed to say strongly disagree but I have to tell you I sometimes feel that I’m weak.”

While Margie strongly disagreed with the idea that people with depression were weak, she admitted that “[she] sometimes [felt] that way.” She went on and said

I still think, unfortunately, there are sort of stereotypes and myths that are well engrained in our society and therefore well engrained in me, some more than others though, especially the one about depressive people are

weak. I mean, just like we have internalized racism, I think I have internalized feelings about myself based on being...you know, having emotional problems. And I think they're very hard to overcome, if you could ever overcome them. I mean, you're kind of like always recovering. Sort of like recovering alcoholic, you're kind of recovering stigma, you know?

The Impact of Stigma

Many of the respondents believed that depressed individuals were treated differently by others. See *Table 3.2*. They also endorsed the idea that Black Americans in general were more likely than themselves to believe that being depressed set people apart from others. When asked, the majority of the respondents stated that Blacks would endorse the idea that people with depression were treated differently. *Again, see Table 3.2*. Richard felt that fear concerning how they would be treated kept Blacks from seeking professional help. He joked that Blacks felt that “all they're gonna do is give me some medication and people are going to tease me.” Kamilie, whose “core of people that [she] socially interact[ed] with [were] Black,” said that she that the “feared some type of rejection from people” if she were to tell them “the real deal about how [she] was feeling.” Sidney said that Blacks may be less willing to discuss their mental health problems because she “[didn't] think that they want people talking about them” or that “you didn't want people to treat you differently, like you have a problem.”

These fears of being stigmatized and treated differently or violating some cultural taboo contributed to some respondents hiding their depression. Carol felt that being viewed as crazy forces many people to hide their illness, saying

that people make be reluctant to “tell anyone cause people might think [they’re] crazy.” Also, underlying several respondents’ statements was the belief that depressed Black Americans had more to lose if/when their depression diagnoses were revealed or discovered. Kamille addressed this belief of being what I would like to term as “outed and ousted,” stating

I think that my perception of or my experience of being a Black woman in a department full of White people, one of my fears was that I wouldn’t be taken seriously as a student if it was widely known that I was depressed. Or there would be a perception that I can’t perform to the best of my ability or get things done. And I think my experience as a Black woman colors that perception of the situation for me. I think I didn’t want it to be another strike, so-to-speak, on my record. And I feel like they might be able, or certain people might be willing to give Suzie (laughs) White grad student more leeway than they would me automatically, so for me coming in talkin’ about I’m depressed, and I need special concessions, I think I just thought that I wasn’t likely to get that. In fact, I thought that people might just look at me as...that I’m just incompetent and don’t belong here.

She later shared this sentiment again, stating it this way:

I think it goes back to what I was talking about before: there’s this perception I’m already Black, I’m already a woman, like there’s already strikes against me, so I think people might be willing to think that, if you are depressed, people will treat you differently. Like, it’s another strike against your record.

Kamille believed a failure to keep up appearances or “to appear a certain way one hundred percent of the time” had very real consequences: “people aren’t gonna take me seriously. Or they’re gonna try to prevent me from, you know, finishing this degree or whatever.”

Pushing Back Against the Stigma

Many of the respondents reported that they pushed back against stigma of

depression by seeking treatment. Richard felt that stigma should not deter people from getting help. He said that he “learned you’ve got to look over the stigma, look over the whatever, because you’re doing something to help yourself.” Denise said

I kinda felt weird about having formal sessions with a psychotherapist initially because I feel like depression is really stigmatized and I feel like, you know, if people know that you’re going to a psychologist, they think that you’re crazy, so...I think now I feel better about that kinda thing.

Others believed stigma must be confronted by disclosing their depression to others. Janelle said that “once you talk about it, get it out on the table, and people start to understand it, I think it’ll be less of a taboo.” Kamille talked about how she eventually told her family and close friends about her depression. She said

It almost seemed like it was becoming like a big secret, and I didn’t want it to be like that. Like I didn’t want to have something else on my plate where, you know, like I accidentally mentioned going to therapy or like taking medication, and people are like “what?” You know? Like, “when did that happen?” So, I didn’t want it to be like a secret because I didn’t feel like I had anything to hide from them.

Coming to terms with her depression helped her realize and acknowledge “I’m still Black. I’m still the same person I was before. It doesn’t make me weak.”

A few respondents expressed that this study and their participation in it was a way of challenging the stigma around mental illness. Carol stated “it’s really a great thing that you’re doing, and it’s very needed.” Shalesa “really appreciate[d] this opportunity to talk about depression because it doesn’t come along often enough at all.” She went on to say that she was “really excited” when

she saw the flyer for the study “because [she] wish[ed] that [she] had access to something years ago when [she] was really struggling, and [she] hope[d] that whatever becomes of this research that it, it helps someone else.” However, one respondent suggested that instead of focusing on differences in experiences, we should instead focus on the universality of the disorder.

I dont know why...why do society in general have to divide, red line, different cultures, you know? It just seems like to me that everybody gets depressed every now and then or whatever. Why would another culture be depressed more than or be more susceptible to depression than another. I don't understand why society deal with people like that.

Some respondents recognized that their personal attempts to push back against the stigma could also push against the stigma that existed in Black communities at large. Elisa described her process, sharing

I think the fact that I insisted on, after a while insisted on talking about it as if it was something real and not like some whiny b.s. that, you know, uhh, like my mother, you know, might...you know might've said, like you know, “White people talk about stuff like that.”

Derrick addressed the image of strength and said that treatment could support or aid those cultural images: “if depression is a feeling that’s going to make you ill, then treatment is going to come in and show you how to avoid it, or correct it, or make you feel stronger.” Drucilla challenged the image of people with depression as “crazy” people who see a “shrink,” saying that therapy is simply “talking to somebody cause you’re depressed,” “not seeing a shrink.”

Discussion

The Impact of Stigma on Black Americans with Depression

Stigma is a major barrier keeping many people with mental health problems out of services. For Black Americans, the impact of stigma can be more detrimental in that it is not the only marginalizing marker they must endure (Bolden & Wicks, 2005; Conner, et al, 2010b; Gary, 2005; Matthews, Corrigan, Smith, & Aranda, 2006). This study sought to learn more about how Blacks thought about individuals with depression and those who engaged in treatment. Also examined was how respondents understood, experienced, and combated stigma and how it functioned as an impediment to help-seeking and treatment.

The results of this study highlighted the stigmatizing messages Black Americans can receive about depression, help-seeking and treatment. Respondents discussed their belief that Black Americans in general see people with depression as “crazy” and/or “weak.” As shown in previous research (Alvidrez, Snowden & Kaiser, 2008; Calloway, 2006; Jackson, 2006; Mishra, et al., 2009), these beliefs made it difficult for those experiencing depressive symptoms to seek help for their problems. Respondents’ reports of hiding their symptoms or the fact that they sought treatment to avoid being labeled or treated differently echoed findings of other studies (Conner, et al., 2010c; Matthews, Corrigan, Smith & Aranda, 2006; Mishra, et al., 2009; Roberts, et al., 2008). Some respondents attributed the stigmatization of those with depression to a lack of education about the disorder. However, other respondents believed that individuals themselves can hold these beliefs, internalize them, and thus, feel as

though their social statuses and/or standings in their community are at risk or being challenged. It was *these* fears that respondents stated forced some to hide their depression and others to turn to those outside of their Black social networks and communities to seek support (Goffman, 1963).

One of the more novel ideas to emerge from this study was the fact that the negative characteristics of those with depression were often racialized and/or gendered. A number of respondents talked about how being “crazy,” “weak,” or depressed itself were traits of other races, namely Whites and particularly women. The idea that depression was something that did, or should, not affect Blacks was clearly implied if not stated outright. By using racialized and gendered language to describe depression and the depressed, some were forced not only to contemplate their illnesses, but also their identity as Black American men and women. For them, it was not enough to be weak or crazy due to their illness, but also less of a “Black” man or woman. These characterizations of and responses to depression made many respondents feel that depression and treatment were more stigmatized in Black communities. They also shared that talk of depression and treatment was taboo in Black communities, creating feelings of shame in some. The oppressive environment created for many respondents forced some to turn to individuals outside of their family, friends, and community to seek understanding and consolation.

While the belief that depression was more stigmatized in Black communities is similar to findings in previous research (Bailey, Blackmon, & Stevens, 2009; Conner, et al, 2010b; Moran, et al., 2004), several findings go

beyond the current literature. One new finding was that Blacks resort to turning to those outside of their families and racial/ethnic communities for support while hiding their depression within the community to maintain social ties. This finding suggests that Black Americans with depression may feel as though they must navigate multiple identities in various spaces, which can in turn add to their (di)stress. Respondents also discussed the importance of fighting the stigma experienced and seeking help when needed. Some talked about how they combated stigma at the individual or personal level, but they also expressed the need for community level intervention to educate people about depression and the importance of treatment. Many said that studies like this aided that goal.

Limitations and Future Directions

While this study was a major contribution to the study of the stigmatization of depression in Black communities, it is not without its limitations. The major limitation of this study is the fact that the sample of respondents was non-representative. Having a more representative group of participants would have given this study greater insight into how Black communities understand depression and treatment and how stigma is experienced by Black depression sufferers. Another limitation of this study is that beliefs about Black communities were entirely based upon the perceptions of the respondents. The work would have been strengthened by talking with the members of the community who have not experienced depression or other mental health disorders and hearing how they feel about depression, the depressed, and treatment in their own words.

The limitations of this study not only illuminate areas of concern but also highlight directions to take future work in this area. By increasing and diversifying the sample, we can increase the number of men in the study as well as capture a sample more reflective of the Black population at large. Also, with a larger, more diverse sample, we can look more closely at within-group variations in the beliefs held about the stigmatization of depression and treatment. As previously mentioned, future research should also extend beyond talking to depression sufferers themselves and include actual laypersons' beliefs about depression and help-seeking. While it is important to understand the perceptions those diagnosed with depression have about Black Americans' views about depression and treatment, it is equally important to assess the actual community climate about depression and treatment by talking to those who in the community who have not experienced depression. These climate-assessment studies can also be replicated to examine the "temperature" within families and in mental health care settings. Future studies should also look more closely at the practice of going outside of Black social networks and accessing spaces that are non-Black for depression support as well as how Blacks with depression negotiate their positions in both spaces.

Conclusion

While the stigma of mental illness is a barrier for many seeking services for mental health treatment, it is a particularly strong impediment for Black Americans. It is important that research continue to better understand Blacks'

experiences with depression and stigma both inside and outside of Black communities. By understanding their perceptions of their community and its beliefs about them we can look towards designing and implementing interventions that reduce stigma and increase understanding and support *within* Black communities for those that struggle with depression and other mental health problems.

Table 3.1 - Characteristics of Sample (n=17)

Variable	Number	Percentage
Gender		
Female	13	76%
Male	4	24%
Age		
18-21	1	6%
22-29	6	35%
30-39	3	18%
40-49	5	29%
50-59	2	12%
Education		
Some High School	1	6%
High School/GED	3	18%
Some College	6	35%
College Graduate	2	12%
Post-Graduate	5	29%
Diagnosis		
Self	5	29%
Psychiatrist	4	24%
Therapist	3	18%
Mental Health Professional (Type Unknown)	2	12%
Medical Doctor	3	18%

Table 3.2 – Endorsement of Beliefs Related to Stigma (n=17)

Belief	Self	Blacks In General
Depressed people are weak.		
Strongly Agree	n = 0	n = 1
Agree	n = 1	n = 8
Unsure/Don't Know	n = 2	n = 3
Disagree	n = 5	n = 2
Strongly Disagree	n = 9	n = 1
Question Not Asked	n = 0	n = 1
People treat you differently if you are depressed.		
Strongly Agree	n = 2	n = 3
Agree	n = 6	n = 8
Unsure/Don't Know	n = 5	n = 3
Disagree	n = 1	n = 2
Strongly Disagree	n = 3	n = 1

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Chapter Four

Pray, Delay, or Go-Away: Beliefs about Help-Seeking and Treatment among Black Americans with Depression

“And the fact that our culture is the last one that’ll go get help...Every other culture runs to the...doctor or psychiatrist, but we as a people are reluctant to go.”

Introduction

Research has consistently shown that Black Americans utilize mental health services for depression and other mental health problems at a rate below that of Whites (Alegría, et al., 2008; Keyes, et al., 2008; Lasser, et al., 2002; Padgett, Patrick, Burns, & Schlesinger, 1994; Sussman, Robins, & Earls, 1987; Williams, et al., 2007). Most scholars have focused on factors related to finances, insurance and access to explain these differences (Copeland, 2005; Cruz, et al., 2008; Snowden, 2001b; Thompson, Bazile, & Akbar, 2004). While these barriers to care are important, they do not account for all of the difference since racial/ethnic disparities persist even when these factors are controlled. It is important that research look towards more socio-cultural factors as barriers to care, particularly how culturally-shaped beliefs about health and illness impact health behavior. In this study, I use qualitative interviews with 17 Black American men and women to explore how depression, help-seeking and/or treatment are viewed in Black communities as well as to understand how these culturally

shaped messages impact how Black Americans think about depression and approach help-seeking and treatment.

Factors Impacting Mental Health Service Use for Black Americans

According to studies of mental health service utilization in primary care and psychiatric settings, African Americans use these services at a significantly lower rate than Whites (Alegría, et al., 2008; Keyes, et al., 2008; Lasser, et al., 2002; Padgett, Patrick, Burns, & Schlesinger, 1994; Sussman, Robins, & Earls, 1987; Wang, et al., 2005; Williams, et al., 2007). Researchers have explored a number of factors to explain these disparities in service use. One's ability to pay for mental health services, be it out-of-pocket or through insurance, increases one's ability to access and engage in treatment. However, financial barriers or lack insurance appear to have more of an impact on Black Americans' ability to access care than it does for Whites (Copeland, 2005; Cruz, et al., 2008; Snowden, 2001b; Thompson, Bazile, & Akbar, 2004). When compared to Whites, Black Americans are more likely to be poor, lack private or employer-based insurance, and are more likely to have public insurance like Medicaid, making treatment engagement more difficult (Copeland, 2005; Schnittker, 2003). Racial/ethnic minority consumers also report the potential loss of income as a significant barrier to care more often than Whites (Ojeda & McGuire, 2006).

Not having the money to pay for services, lacking insurance, or the fear of losing money from work to attend treatment all impact an individual's ability to

initiate or continue treatment. However, although these difficulties may prevent many Black Americans from accessing care, they do not prevent all individuals experiencing financial hardship from engaging in care. Conversely, having insurance and financial means is not always a facilitator of service use.

Research has shown that even among employer-insured, non-poor African Americans, out-patient service utilization rates lag largely behind Whites (Ayalon & Young, 2005; Diala, et al., 2000; Kimerling & Baumrind, 2005; Padgett, Patrick, Burns, & Schlesinger, 1994; Snowden, 1999). This fact prompts researchers to view the topic of service use among Black Americans for mental health problems with a more complex lens.

Another major factor in one's ability to engage in mental health treatment during times of distress is his/her physical access to services. Having easily accessible quality mental health services (in both physical location and appointment/services procedures) as well as a number of practicing clinicians can increase the likelihood that one will engage in services for mental health problems. However, racial/ethnic minorities often do not have access to this is type of care (Copeland, 2005; USDHHS, 2001). Black Americans are more likely to experience a lack of transportation, long waiting lists or no available or too few services in their area than Whites (Ayalon & Alvidrez, 2007; Copeland, 2005). Also impacting the ability to access services for persons of color is the fact that services are often inadequate for meeting their cultural/social/personal needs. Encountering culturally incompetent providers; insensitive, invasive, impersonal, judgmental practitioners and practices; or services that do not match their

treatment preferences, can impact Black Americans initial and continuing engagement in mental health services (Cooper-Patrick, et al., 1997; Cruz, et al., 2008; Duncan, 2003; Thompson, Bazile, & Akbar, 2004). Black Americans also may not know how to access mental health services or may not even recognize such services as a means of addressing their distress (Ayalon & Alvidrez, 2007; Cruz, et al., 2008; Thompson, Bazile, & Akbar, 2004). Yet, even when racial/ethnic groups have seemingly equitable access and knowledge of mental health services, African Americans are still less likely to use mental health services than Whites (Alvidrez, 1999).

Because racial/ethnic disparities in mental health service use persist even when controlling for financial and structural factors operating as treatment impediments, some research looks beyond these factors to explain patterns of service use. Research is accounting for more personal and/or psychological factors impacting one's access to care. An individual's personal awareness or views of mental disorders and treatment are a large factor in their decision to use mental health services. Some individuals experiencing mental health issues may not think what they are feeling is problematic or might not recognize the symptoms they are experiencing as indicative of illness (Hines-Martin, Malone, Kim, & Brown-Piper, 2003; Thompson, Bazile, & Akbar, 2004; VanVoorhees, et al., 2005). Still others may not even think they have a problem or refuse to accept a diagnosis given (Cruz, et al., 2008; Hines-Martin, Malone, Kim, & Brown-Piper, 2003; VanVoorhees, et al., 2005).

Other personal factors that impact an individual's use of services for mental health problems lay in how an individual believes emotional distress should be addressed. While many may believe that symptoms related to mental distress are best helped with the assistance of a professional, some Black Americans simply believe that the symptoms will go away or alleviate on their own (Anglin, Alberti, Link, & Phelan, 2008). Many Black Americans also believe that they can, or should, deal with these kinds of problems on their own without outside intervention (Barksdale & Molock, 2008; Cruz, et al., 2008; Snowden, 2001b; Thompson, Bazile, & Akbar, 2004). Another common approach Black Americans use to deal with emotional problems is to rely on God or religious practices to carry them through difficult times (Ayalon & Alvidrez, 2007; Cruz, et al., 2008; Snowden, 2001b).

Many Black Americans have also expressed concerns and/or fears about seeking out medicalized care for emotional problems. Some African Americans report being afraid of the types of treatments recommended. Many do not trust the use of medications for depression, and others have expressed concern over brainwashing or mental manipulation in psychotherapy (Alverson, et al., 2007; Barksdale & Molock, 2008; Cruz, et al., 2008; Sussman, Robins & Earls, 1987; Thompson, Bazile, & Akbar, 2004; Thurston & Phares, 2008). Many of these fears are rooted in a historical mistrust of the medical care system and practitioners (Cruz, et al., 2008; Snowden, 2001b; Thompson, Bazile, & Akbar, 2004; Thurston & Phares, 2008; Whaley, 2001). Some Black Americans also believe that therapy in particular violates feelings of privacy and confidentiality

(Barksdale & Molock, 2008; Boyd-Franklin, 1989; Thompson, Bazile, & Akbar, 2004).

Often influencing the personal factors that impact mental health service use are factors best described as socio-cultural. A small group of researchers have explored the role of these factors in the use of mental health treatment. For many, family is the "primary group that gives meaning to, provides interpretation for, and helps create a response repertoire for developing and maintaining certain behaviors," including health behaviors (Bagley, et al., 1995, p. 636). Therefore, Black families who support positive health behaviors like seeking out professional help in times of distress can facilitate an ill individual's engagement in mental health treatment (Hines-Martin, Brown-Piper, Kim & Malone, 2003). Also, some Black Americans may engage in services because they believe that their familial relationships can be improved by addressing mental health problems (Schnittker, Pescosolido & Croghan, 2005).

While some of the aforementioned socio-cultural factors aid in an individual's decision to seek and engage in mental health service use, they can also be used to explain persistent racial/ethnic differences in service utilization rates. We know that families define and shape the social norms by which members of the family, social and/or cultural unit live. For many racial and ethnic minorities, seeking services may be viewed as being outside of the social or cultural norm (Barksdale & Molock, 2008; Cruz, et al., 2008; Snowden, 2001a). Black Americans in particular report fears of being viewed negatively by family members and friends (Alvidrez, Snowden, & Kaiser, 2008; Barksdale & Molock,

2008; Cruz, et al., 2008; Hines-Martin, Malone, Kim, Brown-Piper, 2003). In a sample of African American college students, the strongest predictor of intention to seek help for mental health problems was perceived negative family norms (Barksdale & Molock, 2008). Students who perceived negative family norms were less likely to seek help than students who perceived more positive family norms (Barksdale & Molock, 2008). Another study investigating barriers and facilitators of mental health treatment among a group of African American consumers also identified fear of violating familial norms as a barrier to treatment (Ayalon & Alvidrez, 2007). A number of respondents reported being hesitant to tell family and friends they were seeking treatment and others reported never sharing with family and friends that they sought out mental health services to address their problems (Ayalon & Alvidrez, 2007). While these two studies highlight the importance of exploring socio-cultural messages to care, they do not explicitly explore socio-cultural barriers to care and do not focus specifically on individuals with depression. Also, their study populations (college students and those actively struggling with severe mental illness) make their results less generalizable.

Many factors impact the ability of a person experiencing mental health distress to seek help and make use of professional services. These factors create a unique, complex picture for persons in treatment at various points in engagement. While we know this, the bulk of the research still focuses on access to care and the financial and structural barriers that impede that access. Culturally-shaped notions of health and illness also have a serious impact on

how individuals engage in help-seeking and how they view service use when ill, yet they receive less attention in the literature. It is important that we look more towards the messages individuals receive about depression, help-seeking and/or treatment and how these messages are influenced by culture. Culture influences how illness is defined and its etiology; how symptoms of illness are understood and communicated; and how beliefs about depression, help-seeking, and treatment are created and disseminated (Good, 1997; Karasz, 2005; Kleinman, 1980a; Kleinman, 1980b; Schnittker, Freese, & Powell, 2000; Shellman, Mokel, & Wright, 2007). By understanding culture, scholars can better understand the help-seeking behavior of Black Americans with depression.

Specific Aims

The current study was designed to look more closely at the impact of socio-cultural factors on help-seeking and treatment for depression. I wanted to explore culturally-shaped beliefs about depression, help-seeking and treatment and better understand their subsequent impact on treatment engagement. Through qualitative interviews, I sought to identify culturally-shaped beliefs Black communities hold and understand their impact on how respondents thought about depression and treatment as well as how they approached help for depression. Respondents discussed the messages they received that not only defined depression but also defined help and outlined how distress should be addressed.

Method

Sample/Study Participants

This study sought to speak with individuals who identified as Black or African American, were 18 years of age or older, and responded “yes” to at least one of the following: 1) has felt sad, empty or depressed for 2 weeks or more during their life; 2) has been told by a doctor, pastor, co-worker, family member or friend that they were depressed; or 3) has seen a doctor, counselor or mental health professional for depression. A total of 17 Black American men and women were recruited using flyers posted at local colleges and universities, libraries, area churches, social service agencies, doctors’ offices and outpatient mental health organizations. The majority of the 17 participants were female (n=13). See *Table 4.1*. Participants’ ages ranged from 21 years of age to 57, with the majority of participants falling in the 22-29 and 40-49 age ranges. Nine participants were diagnosed with major depression by a mental health professional, 3 were diagnosed by a medical physician, and 5 were self-diagnosed. Collectively, the study participants had achieved a high level of education with 5 completing or pursuing post-bachelor’s education. Two participants were college graduates, 6 reported completing some college, 3 finished high school or received a GED, and one participant, the eldest in the study, did not graduate high school, finishing the 11th grade.

Interview Procedures

Participants were recruited during the summers of 2007 and 2008.

Interviews were conducted in locations the respondents chose and included respondents' homes and local coffee shops. The interviews ranged from 30 minutes to 2 ½ hours and were audio-recorded with the participants' permission. All participants' names were changed to maintain confidentiality.

Interviews were largely semi-structured and open-ended. See *Appendices for instruments*. They were conducted using an interview guide designed to have participants reflect on their experience(s) with depression, the cultural messages they received regarding depression and how those messages shaped their thoughts about depression and help-seeking. Participants were also asked about the opinions of a series of statements about depression and Black Americans. They were also asked to assess how Black Americans in general would respond to the same series of statements.

Analysis

The interviews were audio-recorded with the participants' permission and transcribed verbatim by the primary investigator, trained research assistant, or professional transcriptionist. Many of the "umms," "likes" and "you knows" were removed when appropriate to improve the clarity of the message. The primary investigator used HyperResearch software to code and analyze all of the transcribed interviews and to identify relevant themes. While the interviews conducted yielded a wealth of information about Black Americans' experience with depression, I focused particularly on ideas about depression, help-seeking,

and treatment. For the purposes of this article, themes related to the impact of culture on treatment were highlighted.

Results

During the interviews, respondents talked at length about their experiences with depression and help-seeking. A number of themes emerged related to beliefs held in Black communities about depression, help-seeking and treatment as well as the impact of these beliefs on the respondents' personal engagement in mental health services.

Treatment-related Beliefs about Depression

How depression is viewed affects how treatment is thought about and approached. Several respondents shared beliefs they felt Black communities held about depression. One set of beliefs centered on the idea that depression was not a real illness. Elisa stated that "Black people don't buy depression. They, especially older people, just think it's a crock." Laura believed that this was not only shared at the community-level but also within homes, stating that "at home, [she] kind of felt like, there wasn't any such thing as depression. It wasn't real." Other respondents stated that Black Americans saw depression as an illness, just not a serious one. Although almost all of the respondents believed that depression was in fact a serious illness, nine out of seventeen respondents believed that Black Americans at large did not. See *Table 4.2*. An extension of the idea that depression is not an illness, or not a serious one, is the idea that

depression is simply a response to life's challenges and circumstances. Elisa stated that many Black Americans believe that "feel[ing] bad all the time is just how life is," and do not "see [that] as depression."

Some respondents also believed that Black Americans at large felt that depression was not an illness that affected Blacks. Kamille stated that in Black communities there was a "perception that Black folks don't get depressed," or as Janelle put it, that "it was non-existent in the Black community." Janelle went on to express her frustration with the belief that depression does not impact Black Americans.

I guess the attitudes that they have about it bothers me 'cause they think it can't happen to them but, I think "I'm Black and it happened to me," so...(laughs). They just don't acknowledge it and that bothers me.

Some respondents also felt that ideas and/or discussions about depression and subsequent treatment were often racialized in Black communities. Elisa said that when she tried to talk about her depression, her mother told her that "White people talk about stuff like that." Kamille's responses indicated that these ideas about depression were not only racialized in Black communities but gendered as well:

There's this perception that White women, they can cry and fall apart and they're depressed and they take their medications and whatever, but Black women aren't like that. (laughs) You know?

While many respondents discussed the perception that depression was not real or, at the very least, not serious in Black communities, some believed that the issue among Black Americans was more of an unwillingness to

acknowledge its existence. Shalesa said that “often times in the African American community, there’s more reluctance to acknowledge that depression is an illness,” stating that many may see it as “airing dirty laundry.” Kamille agreed, saying that many Black Americans want to “keep all [their] problems in-house” and “not talk about it.” The belief that there was “secrecy” around depression in Black communities was not only shared by Shalesa but others, with some believing, like Laura, that being depressed was “almost shameful” in their communities.

Beliefs about Treatment

Not only did respondents discuss beliefs Black Americans held about depression that have an impact on how help-seeking and treatment are viewed, they also shared ideas about how treatment itself is seen in Black communities.

Medicalized Treatment

Many respondents believed that Black Americans do not seek treatment for depression because they view it as something that does not require *medical* intervention. While only one respondent personally did not think you should see a doctor if you were depressed, nine respondents believed that Blacks at large would not think you needed to see a doctor. *See Table 4.2.* According to respondents, the strongest beliefs held by Black Americans were those of more medicalized forms of treatment. Whether it was going to therapy or taking

medication, respondents including Miller believed that Black Americans were “reluctant to seek help” for depression. He went on to say that

Our culture is the last one that'll go get help, you know what I'm saying? Every other culture runs to the...doctor or psychiatrist, you know what I'm saying? But we as a people are reluctant to go, you know?

Janelle agreed. She felt that people of “other races acknowledge [depression], accept it, do what they need to do, and Blacks don't.”

Respondents had a number of theories to explain this “reluctance” towards service use for depression among Black Americans. From her conversations with Black Americans with depression, Sidney did not “think that [Blacks] want[ed] to take medicine, a lot of them. That's what I've seen.”

Richard takes the idea of medication a step further, suggesting that Black Americans may feel that treatment is not worth the hassle: “all [doctors are] gonna do is give me some medication and people are going to tease me.”

Drucilla also believed that Black Americans felt that treatment was an inconvenience. She said that Black Americans were unwilling to “go to counseling” like she did to “deal with the depression,” feeling that it was “time consuming” or that therapists were “nosey.” Other respondents, including Elisa, felt that Black Americans believed that “therapy and treatment and meds” were a “crook.” Shalesa stated that in her practice work she encountered a severely depressed Black man who was “very much against anti-depressants because he doesn't want to ‘pop a pill’ to feel better.” Also, Kamille believed that Black Americans held racialized views of treatment that kept them out of treatment:

“therapy is for White people; that’s a big one.”

Several respondents, namely males, discussed their experiences of medical mistrust and racism. They believed that similar experiences may keep Black Americans at large from seeking treatment. Some of these respondents talked at length about how patients of different races received different types of medical care. Richard stated that Black Americans are “treated by the medical establishments different than other races, even with the same insurance coming from the same companies or at the same income.” Keith believed this was due to “latent and overt prejudice, especially against [Blacks].” Some respondents believed that these doctors’ biases against Black Americans result in a different quality or level of care. Derrick believed that Black Americans perceived that they did not receive quality or an appropriate level of care

because [they’re] Black, and just the way society deals with African Americans. Even though the treatment is there, you feel like you’re not getting the medical attention that you ought to get to than if you were another race, let’s say if you were an Asian or Caucasian or Hispanic.

Richard said that

A lot of times, doctors are afraid to give a medicine that may work thinking that since they come from poverty they may abuse the medication. It’s just crazy (laughs) when people need help like that. I’ve seen this stuff in my life: giving people of other races priority treatment, the best groups, the best times with the one-on-ones, you know? Not really having them work on their issues to the level where it’s going to help them or pretty much having a case load that’s too much and really just trying to weed people through.

Miller also believed that Black Americans were treated differently than patients of other races.

They did a study, some medical doctors, they gave them the charts, Black and Whites, and we had the same occupations, the same insurance and yet each time (knocks on the table) they recommended further testing for the White person. And when they were confronted with it... They would tell somebody like me, and I've experienced this, I've had to change medical doctors who tell me go home and take Ibuprofen. (Knocks on the table as he speaks) They refer the White person to further testing, you know?

Miller went on to say that

Any other race, they will prescribe their new technology drugs to them and they will prescribe Prozac [an older drug] to me. Some of it may have to do with economics or being able to afford a certain medication or the insurance. I said, "well, what about that new drug?" "Well, your insurance won't pay for that." And they will prescribe me a medication that was out in the early 80s, 70s, you know what I'm saying? And you've got drugs that have come out in 2006, 2008 for it and they're better, you know what I'm saying? There's side effects. And then you have them that and they really don't listen to you.

Other respondents also expressed skepticism around psychotropic medication. Kamille discussed her initial reaction to the idea of treating her depression with anti-depressants.

I was really distrustful of medication. That may be a cultural thing, too. I think about like mistrust of doctors and how doctors just wanna medicate you, and I don't know. Or I think about stuff like...the Tuskegee syphilis experiment comes to mind. There's this perception that you should be distrustful of what White doctors have to say or to be really suspicious of their motives, I think. So, at first I was really hesitant about even trying medication. Or I guess there was a perception that doctors aren't necessarily, looking out for your best interest.

Some respondents feared that their provider, if of another race, would not understand them or their experience. Kamille stated that she was

really distrustful of therapy, especially working with a White therapist, which my therapist actually happens to be White. At first when I came in and talked to her, I really didn't think that she would understand what I was going through.

Shalesa also feared a White therapist would not understand her, but she also discussed an apprehension that a Black doctor would understand the fact that she was depressed.

I've always been nervous about going in for treatment and if I have a White therapist or a White doctor, are they gonna understand where I'm coming from? And also, I've worried about if I have a Black therapist or Black doctor, are they gonna understand where I'm coming from?

After further explanation, it is best stated that Shalesa felt that the White therapist would not understand her as a Black woman and the Black therapist would not understand why she, as a Black woman, was depressed.

Alternatives to Medicalized Treatment

Although respondents discussed why they believed Black Americans are reluctant to engage in medicalized treatment for depression, they also shared what strategies they *did* believe Black Americans would employ to address depression. Some respondents believed that Black Americans at large did not think you had to do anything to deal with depression, that it was something you just got over.

"As a culture a lot of us think this is just something you get over." – Richard

"I think for a lot of Black people, it is just something you can just over." – Laura

"Especially with my African American friends who have depressed mood, [it's] I'm depressed but don't really do anything about it. They don't see it something that they need to do anything about." - Elisa

Twelve out of seventeen respondents felt that Black Americans would agree with the idea that a person only had to think more positively to address his/her depression. Only one respondent personally agreed with this statement. Eleven respondents felt that Black Americans in general believed that depressed people only needed the support of family and close friends to get better. Only one respondent strongly agreed with this belief herself; the same respondent who also agreed that depression could be addressed through positive thinking. Denise believes that Black Americans think that “having the support of your family, friends is gonna help more than going to talk to a stranger.” Others believed that Black Americans turned to family because of desire to keep their problems private. Richard said that they simply “don’t want people outside the family to know” about their depression. Sidney agreed, stating that some Black Americans “may not be so open to just be telling people that [they are depressed] unless they’re, you know, your close friends or family members.”

Thirteen respondents out of sixteen thought that Black Americans at large believed that prayer alone was enough to deal with depression. Only one respondent personally agreed with this approach to depression. This was the same respondent who thought favorably of positive thinking and the support of family/friends as ways to address depression. Janelle says that more than other races, “Black people are so religious, and they always turn to God for everything,” a fact that she admits frustrates her. Denise agreed, stating that “Black people believe more in religion than medicine or therapy...that prayer is gonna help more.” Laura, too, felt that this was the case in Black communities.

“I also think that religion is a little more emphasized [in Black communities], so there’s more of a ‘speak to God’ kind of thing.” Elisa stated that “because [depression] is not seen as an illness,” and rather as an “issue of faith,” many Black Americans believe that “you’re supposed to just pray about it.” Richard agreed that depression is seen as a faith-issue, stating “they feel that prayer and meditation or whatever could conquer everything” and that if the symptoms did not go away that “[other Black Americans] would think maybe you are not doing it right or you don’t have enough faith.” Other respondents also discussed how prayer is used as means of addressing depression. Kamille said when experiencing depressive symptoms, Black Americans “think that you can just pray ‘em away,” that “you just pray about it and God will take it away,” a sentiment that she felt was far too simple. Miller believed that Black Americans turn to prayer because “this is what they’ve been doing for so long.”

Even though most respondents personally believed that prayer alone was not enough to address depression, some struggled and stopped short of declaring that there were no benefits to faith. Although Keith disagreed with the use of prayer as treatment, he admitted that “a few years ago, [he] would agree.” Richard struggled with his response: “See that’s a hard question because you can’t measure someone’s faith. Faith has healed a lot of people.” Derrick felt that medication, counseling and the like were used to treat depression if a person’s faith wasn’t strong enough: “If they have a strong faith, they don’t need anything else. But if their faith is not that strong, they may feel they need a doctor, therapist, a counselor, some medication. Still others saw the benefits of prayer

but still believed like Sidney, that “you can pray but you need to put some action behind that.”

Two respondents held particularly strong opinions of the use of religion or faith to address depression. As stated earlier, Janelle openly expressed frustration at the belief that all one needed was prayer to address depression.

For Laura,

That whole religion thing, made me less religious actually, almost to...not atheism but agnosticism because I didn't get any answers from God. So it made me almost really annoyed with the whole “speak to God” thing.

Miller believed that Blacks sought out alternate methods like prayer for addressing depression because historically, they have been shut out of more formal modes of care.

We've been so used to being on a level without any treatment for it, but to go to a church, you know what I'm saying? You can imagine in the sixties when a lot of stuff wasn't available to us, you know what I mean?

Impact of Beliefs on Treatment

Respondents spoke a great deal about the existence of culturally-influenced beliefs about depression and treatment in Black communities. While most believed these views keep many Black Americans out of mental health services for depression, the actual impact these beliefs had on the respondents themselves varied. For some, the beliefs had little to no impact while others felt the beliefs impacted them greatly. Some respondents also felt that these beliefs only *initially* had an impact on their experiences with depression, help-seeking

and treatment while others believe that some of the beliefs' effects linger.

Impact on Thoughts about Depression

Nine out of sixteen respondents believed that culturally-shaped beliefs about depression, helping-seeking and/or treatment had some impact how they thought about depression at one time or another. See *Table 4.3*. Kamille felt that these beliefs “absolutely” had an impact on how she viewed depression early on.

Absolutely! (laughs) Especially the perception that Black people don't get depressed [and] all you have to do is think positively. I think all of those impacted how I thought about depression almost to the point where I would say that I thought of depression as different for Whites than Blacks.

Seven out of sixteen respondents believed that these cultural messages had no impact on how they thought about depression. Denise believed that being exposed to her mother's depression before her own experience with it helped her see the disorder more accurately.

I think because I learned a lot about depression before actually having...(pause) I've learned a lot about it, and my mother had actually had her depression before mine, so I think I was just able to be more sympathetic about it and see that a lot of those statements are not really true.

Keith said that while these ideas did not have an impact on him personally, he recognized that they could affect others.

No, not me. I think other people, but I don't think myself. Like I know people who really think it's something you can just shake off, you know? When it hits you, you can just shake it off. And that's not my experience.

Impact on Help-Seeking In General

Twelve out of sixteen respondents believed that cultural messages about depression, help-seeking and/or treatment had at least some impact on how they looked at and asked for help for depression. See *Table 4.3*. When Shalesa was asked if these messages had an impact on her, she responded with an emphatic “oh, yeah!” Laura believed that these messages were “the reason why [she] waited so long to ask for help.” She went on to say that these culturally-shaped ideas also

“Affected how [she] looked [for help] because [she] couldn’t just go to any doctor. [She] wanted to go to someone where [she] knew it wouldn’t get back to [her] family. So that’s why [she] went to the school [for help].”

Denise felt that these culturally-held beliefs were “one of the reasons [she] didn’t tell that many people.” She went on to say

Some of my friends are Black, and I didn’t think that...(pause) They have more positive attitudes, and I think they’re more of the kinda people who would say you should think more positively rather than understand that I was going to a therapist or anything like that.

Carol stated that “if [family and friends] never acknowledge that they get low or have low points in their life or they feel depressed at times, you’re going to think ‘oh well, they don’t feel depressed at all.’” When asked if this was her experience, she said that it was and elaborated

Cause my grandma...I’ve never seen my grandma cry, ever. And I’m like, “well I know she cry; she has to.” (laughs) But I’ve never seen her cry, so I equated that with her being strong and emotionally strong. And she’s very religious also. So I don’t know what that plays in it, but I just didn’t understand it growing up. And she’s been through a lot. (laughs)

She has something to cry about. But I actually talked with her and she does justify not crying. You know, “if you sit around and wallow, what does that do?” She’s one of those type of people.

The remaining four respondents did not believe that these culturally-shaped beliefs had any impact on how they looked at and asked for help. Keith reflected on the current impact of culturally-infused messages and stated that the beliefs held by his community would not have “stopped [him from seeking help] either way.” He said that he could not let those ideas keep him from recognizing his depression and doing something about it because he “[knew] what the alternative [was].” For him, that alternative was “self-medication” and he did not “want to go back there.”

Impact on Talking about Depression

Eleven out of fifteen respondents stated that cultural beliefs held in Black communities about depression, help-seeking and/or treatment affected whom they spoke to about their depression. *See Table 4.3.* When asked if these messages affected who he spoke with about his depression, Miller said that they did: “Yeah, some people are ignorant to [depression]. The family, my dad in particular, a lot of people was ignorant to it, you know?” Laura stated that these culturally-shaped ideas “made the whole coming out as depressed more difficult.” Kamille talked about the cultural “perception that Black people don’t get depressed” and how it had a particular impact on how she talked to people about her depression.

The core of people that I socially interact with are Black. I think that would've made me less likely to come and be like, "hey, guess what? I'm depressed." So, I think that made me even more hesitant to broach the subject or to really talk about the real deal about how I was feeling. I guess I felt...(pause) like I feared some type of rejection from people, or I don't know, I guess just hearing the same old thing like "well, if you just pray hard enough then it'll get better" when based on my experience, it just couldn't be as simple as that.

Elisa stated that these culturally-shaped ideas impacted who she "was willing to tell" although she admitted that "[she] didn't think [depression] was an illness or anything either until [she] got to be 19 and got out of [her] house and was around a bunch of White people (laughs)." Denise also talked about role race played in who she spoke with about their depression. She stated that "everybody [she] told about it was White." Keith, who said that the beliefs did not impact his thoughts about depression, help-seeking, and/or treatment, said that when it comes to impacting who he talked to about his depression "Now, that may be true." He went on to say that "there is a lot of the old stereotypes that's still here and living large." When asked to elaborate of the stereotypes, Keith responded, "Just that one word: 'crazy.'" Three respondents stated that the culturally-influenced ideas about depression, help-seeking and/or treatment did not impact who they talked to about their depression. One respondent was unsure how the beliefs impacted who she spoke to.

Impact on Thoughts about Treatment

Ten respondents believed that culturally-shaped beliefs about depression, help-seeking and/or treatment impacted how they initially thought about

treatment. See *Table 4.3*. Keith said that he was hesitant to engage in treatment “because of the labeling.” Shalesa felt uneasy about treatment; she said that she was “fearful of the response [she] was going to get if [she] went in for treatment.” Kamille said that the messages she received made her “distrustful” of therapy and medication. Laura said the beliefs “definitely” made “going on anti-depressants...a little harder.” Margie felt that messages about individuals with depression being weak had an impact on her feelings about treatment.

I felt I should be able to get better on my own, that it was a weakness in my personality, a defect in my personality and that there’s something other than the illness (pause) that there’s something basically wrong with me and defective and that I should be able to make myself feel better

Six respondents said these types of cultural messages did not have an impact on how they thought about treatment.

While respondents talked at length about unfavorable beliefs held personally or by Black Americans at large, many did acknowledge the benefits of treatment for depression. Keith discussed the benefits of medication, saying that taking medication “helps you to get some equilibrium” in your feelings and symptoms. Drucilla found that “talking [things] out was much better than keeping [them] inside.” Doris admitted that she did not like treatment at first, “but after [she] got into it and learn[ed] more about it, [she] liked going to treatments and therapy, groups.” Denise was also apprehensive about therapy but eventually found it helpful.

I kinda felt weird about having formal sessions with a psychotherapist initially because I feel like depression is really stigmatized, and I feel like if

people know that you're going to a psychologist, they think that you're crazy, so...(pause). I think now I feel better about that kinda thing. But sometimes, it just amounts to you needing someone to talk to and nothing really being seriously wrong with you.

Discussion

This study sought to better understand patterns of help-seeking and treatment use among Black Americans by exploring the culturally-shaped messages they received about depression, help-seeking and treatment for depression. A number of themes related to these messages emerged and the impact on treatment was discussed.

Respondents reported that people in Black communities did not view depression as an illness, and those that did, did not believe it was a serious problem (Hines-Martin, Malone, Kim, & Brown-Piper, 2003; Thompson, Bazile, & Akbar, 2004; VanVoorhees, et al., 2005). Respondents also felt that depression was not seen by Black Americans as an illness that affected their communities. Conversely, some respondents believed that Black Americans felt that life was supposed to be difficult, and thus, depression was something you just dealt with and got over without medical intervention (Anglin, Alberti, Link, & Phelan, 2008; Barksdale & Molock, 2008; Cruz, et al., 2008; Snowden, 2001b; Thompson, Bazile, & Akbar, 2004). These two divergent opinions reveal that the term "depression" conveys different meanings to different people. Thus, when one is trying to communicate the presence of a serious problem, their distress may be interpreted as a simple, easily addressed issue. And vice versa. More research

should be done to determine how the term “depression” is being used and what meaning it holds for different people.

Some respondents’ believed that Black communities were unwilling to acknowledge the existence of depression. They shared that Blacks may prefer to keep problems “in-house” and feel that going to therapy amounts to “airing dirty laundry.” The desire to protect this sensitive information may lay in communities’ desire to protect collective identity of Black Americans. Because Blacks historically have been marginalized and stigmatized because of their race, they may not want to add another stigmatizing identity (Bolden & Wicks, 2005; Conner, et al, 2010; Gary, 2005; Matthews, Corrigan, Smith, & Aranda, 2006). Also, Black Americans pride themselves on being strong and able to deal with adversity (Thompson, Bazile, & Akbar, 2004; USDHHS, 2001). Because some Black Americans see depression as a weakness, they may see the existence of depression in their communities as a threat to the image of Black strength.

Respondents also spoke at length about the various ways in which help and treatment are viewed in Black communities. Many respondents believed that Black Americans in general were reluctant to engage in more medicalized forms of treatment. They felt that many Blacks were resistant to taking medication and skeptical of therapists, assuming they would be White and not understand their unique experiences, a fact noted by other researchers (Cooper-Patrick, et al., 1997; Cruz, et al., 2008; Duncan, 2003; Thompson, Bazile, & Akbar, 2004). Respondents also discussed how Black Americans believed more in other forms of addressing depression rather than professional services. Prayer, support from

friends and family, and positive thinking were all strategies respondents felt Black Americans preferred over formal treatment, not unlike the findings of previous research (Ayalon & Young, 2005; Cooper, et al., 2003; Jackson, 2006; Neighbors, Musick, & Williams, 1998; Snowden, 2001b; Taylor, et al., 2000). However, respondents also believed that while these alternatives have some benefits, they should not be viewed as the sole mode of treatment for depression. These discussions of treatment again highlighted the issue around the meaning of depression. Depending on how it is being defined, what is seen as appropriate treatment can vary greatly. Again, future research should work to better understand how the term “depression” is understood and what type/severity of distress it represents.

According to respondents, messages about depression and treatment are often racialized and sometimes gendered. Respondents discussed the impression they got that being depressed and/or seeking professional treatment was what “White people talk about” or do. Some also talked about the intersections of race, gender, and class, and their impact on how treatment options are presented and engaged. Medical mistrust and racism were largely talked about by male respondents as a reason why more Black Americans do not seek help. These men believed that while culturally-shaped beliefs discourage Black Americans from seeking professional help, past medical care experiences and discriminatory health practices also keep many Blacks out of care.

The impact these messages had on respondents varied. Some believed that the culturally-shaped beliefs bore no effect on how they thought about

depression, help and treatment, and/or who they talked to about their depression. Most respondents felt that the beliefs had at least some impact, either delaying their engagement in services or influencing who they shared their depression experiences with. Taking the respondents' experiences as whole, the beliefs had less of an impact on how they thought about depression or treatment. This can be attributed to the fact that self-education and exposure could reveal "truths" about the illness and treatment on a personal level, and thus, lessen the impact of beliefs. The greatest impact of the culturally-shaped beliefs, as well as the one with the most lingering effect, was on how respondents thought about help and who they spoke with about their distress. This is evidenced by respondents' feelings that Black communities were less understanding about depression and treatment and that they found the greatest support outside of their communities. It is not surprising that the beliefs would have the greatest impact on help-seeking and reaching out to others because these are the two areas where it would take the education and exposure of multiple parties to challenge the beliefs.

Limitations and Future Directions

While this study highlighted the influence of socio-cultural beliefs on help-seeking and treatment for depression, several limitations should be noted. First, the sample used in this study was non-representative. Future research should be conducted with a more diverse and dispersed Black American population. This will not only offer a broader prospective on issues of mental health and

illness in Black communities but will also allow for exploration of more within-group differences in thoughts about depression, help-seeking and treatment. This study noted that men tended to talk more about racism and medical mistrust. In a larger, more representative study, we can see if this trend holds as well as identify more differences along gender and other demographic lines.

Another important issue that emerged from this study was the realization that the term “depression” can simultaneously hold different meanings in Black communities. For some, depression may be no more than a response to everyday struggles that can be alleviated through prayer and familial support, but for others, may represent a serious mental health disorder requiring medical treatment. Future studies should more clearly explore the language of distress among depression sufferers as well as the community at large and how both groups define the term depression.

Lastly, as mentioned above, future research should extend beyond talking to depression sufferers themselves and can include actual laypersons’ beliefs about depression and help-seeking. While it is important to understand the perceptions those diagnosed with depression have about Black Americans’ views about depression and treatment, it is equally important to assess the actual community climate about depression and treatment by talking to those who in the community who have not experienced depression. These climate-assessment studies can also be replicated to examine the “temperature” within families and in mental health care settings.

Conclusion

While it is true that financial and structural factors can impede Black Americans' access to mental health services, it is important to examine how beliefs about depression, help-seeking, and/or treatment can also operate as a barrier to care in Black communities. Recognizing the impact of beliefs not only gives us a more complete picture of the factors impacting help-seeking and service use for depression, but it offers insight into how depression is understood and subsequently, how help-seeking and treatment are thought about and approached. Knowing this information can help social workers rethink how we engage with a diverse Black American client population and can assist in the development and implementation of more appropriate interventions to increase service use for depression among this group.

Table 4.1 - Characteristics of Sample (n=17)

Variable	Number	Percentage
Gender		
Female	13	76%
Male	4	24%
Age		
18-21	1	6%
22-29	6	35%
30-39	3	18%
40-49	5	29%
50-59	2	12%
Education		
Some High School	1	6%
High School/GED	3	18%
Some College	6	35%
College Graduate	2	12%
Post-Graduate	5	29%
Diagnosis		
Self	5	29%
Psychiatrist	4	24%
Therapist	3	18%
Mental Health Professional (Type Unknown)	2	12%
Medical Doctor	3	18%

Table 4.2 – Endorsement of Beliefs Related to Treatment (n=17)

Belief	Self	Blacks In General
	Number	Number
Depression is a serious illness.		
Strongly Agree	n = 9	n = 2
Agree	n = 5	n = 3
Unsure/Don't Know	n = 2	n = 3
Disagree	n = 0	n = 8
Strongly Disagree	n = 0	n = 1
Was Not Asked Question	n = 1	
You should see a doctor if you are depressed.		
Strongly Agree	n = 3	n = 1
Agree	n = 8	n = 3
Unsure/Don't Know	n = 5	n = 4
Disagree	n = 1	n = 8
Strongly Disagree	n = 0	n = 1
To get better, depressed people only need the support of their family and close friends.		
Strongly Agree	n = 1	n = 2
Agree	n = 0	n = 9

Unsure/Don't Know	n = 0	n = 2
Disagree	n = 11	n = 3
Strongly Disagree	n = 5	n = 1
Prayer alone is enough to deal with depression.		
Strongly Agree	n = 1	n = 2
Agree	n = 0	n = 11
Unsure/Don't Know	n = 0	n = 1
Disagree	n = 10	n = 1
Strongly Disagree	n = 6	n = 1
Was Not Asked Question		n = 1
All you have to do to treat depression is to think more positively.		
Strongly Agree	n = 0	n = 3
Agree	n = 1	n = 9
Unsure/Don't Know	n = 1	n = 2
Disagree	n = 8	n = 2
Strongly Disagree	n = 7	n = 1

Table 4.3 - The Impact of Beliefs (all participants n=16*)

Impact on....	Some Impact	No Impact	Unsure
Ideas about Depression	n = 9	n = 7	
Who they talked to about it #	n = 11	n = 3	n = 1
How they thought about help	n = 12	n = 4	
Ideas about Treatment	n = 10	n = 6	

* One respondent's (Drucilla) answers were removed because she clearly did not understand this series of questions, even when explained multiple times in various ways.

One respondent (Derrick) understood the question to mean did *his* talking about depression have an impact on others; his answer was removed

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Chapter Five

Conclusion

The goal of this dissertation was to better understand patterns of help-seeking and treatment use for depression among Black Americans. I used information gathered from qualitative interviews with 17 Black American men and women who had previous experiences with depression to better understand low service use rates for depression among Black Americans by looking beyond strict financial or access-related barriers and towards more social-cultural factors related to health behavior; explore how culture influences health behavior, particularly examining various aspects of culture as it relates to health behaviors around help-seeking and service use for depression among Black Americans; and give a voice to Black depression sufferers who may feel silenced or ridiculed in their communities for the mental health problems and/or help-seeking behaviors.

This research advanced the scholarship in the area of Black American mental health in several key ways. First, this study reclaims culture as an important lens to view health behavior. I use cultural relativism and health behavior theory to shed light on the impact of culture on how Black American depression sufferers understand Black identity, depression, help, and treatment including service use. Second, the qualitative approach to this work uses

the voices of Black depression sufferers to highlight areas of struggle and conflict as they sought help for their distress. This approach not only amplifies voices that respondents felt were silenced in their Black communities for a variety of reasons, but it offers a way to explore, probe, and better understand the experience of Black Americans with depression. It also highlights the experience of mental health stigma in Black communities and the unique psychological and socio-cultural processes that some respondents went through as they navigated both their illness and their familial/social networks. Next, this work addressed several gaps in the current literature on Black American mental health. The number of studies dedicated to mental health, illness, and wellness of Black Americans has been comparatively small in both the sociological and social work disciplines. Fewer studies explore mental health behavior for depression among Black Americans and do not examine how Black Americans define depression, understand help, and approach treatment for depression. With a focus specifically on depression, this study adds to this area of scholarship. Further, this work pushes the field forward by focusing on the intersection of “Black” and “depressed” identities. It explores how a sample of Black Americans make sense of what it means to be a Black person with depression and examines how respondents understand and resolve conflicts between those two identities. Finally, this study is conducted with intervention in mind. Questions were asked and responses were probed with the goal of understanding how some Black Americans understand depression, help, and treatment so that interventions can be designed and implemented in a way that speaks to this group’s understanding

of mental health and treatment.

I begin this concluding chapter with a summary of the findings of the previous three chapters. I follow with a discussion of the study's limitations and how future work can address these challenges. Finally, I close the chapter by discussing the broader sociological and social work implications, specifically those related to intervention.

Summary of Findings

Chapter 2 of the dissertation highlighted the importance of examining socio-cultural understandings of identity, illness, and help. It not only explored beliefs respondents held related to what it means to be "Black" and "depressed" but also examined how respondents perceived Black Americans at large viewed meaning around being "Black" and being "depressed." Respondents discussed how these two identities conflicted and operated to prevent and/or delay entry into mental health treatment for depression.

Many of the beliefs respondents identified and discussed stemmed from the seemingly synonymous nature of being "Black" and the concept of "strength." The ability to "deal with anything" accompanied beliefs about strength, a sentiment expressed in previous research (Beauboeuf-Lafontant, 2007; Thompson, Bazile, & Akbar, 2004; USDHHS, 2001). While most respondents strongly disagreed with the idea that Black people do not get depressed, a sentiment that they felt Black Americans in general conversely endorsed fairly strongly, they were less likely to disagree with the belief that Blacks could deal

with anything that comes their way. Respondents' feelings on this belief were more closely mirrored how they believed Black Americans in general would feel about this statement. This finding shows that cultural pride surrounding the ability of Black Americans as a people to overcome adversity and struggles persist even though respondents believed that Black Americans were not "invincible."

Respondents spoke about these ideas of strength and invincibility were tied to the historical and social experiences of Blacks in the U.S., something that previous research also noted (Beauboeuf-Lafontant, 2007; USDHHS, 2001). In this study, respondents discussed how this idea related to mental health, specifically depression. Many felt that the message in Black communities were clear: if Black Americans could endure the brutality of slavery and the injustice of racism and discrimination, they could and should be able to deal with anything, including depression. These beliefs undergirded depiction of Black men and women as the pillar of strength described by respondents, images that respondents felt prevented many Black Americans from admitting to or even recognizing symptoms of depression.

Some respondents believed that this lack of recognition was linked to the idea that life was expected to be difficult and Black Americans were built to respond. In other words, these respondents felt that Black Americans did not see depression as a (serious) illness or something that required medical intervention because many Black Americans believe that hard times and adversity are a part of life and that they are expected to show strength in order to

get through them (Anderson, et al., 2006; Beauboeuf-Lafontant, 2007; Hines-Martin, et al., 2003; Thompson, Bazile, & Akbar, 2004).

Perhaps the most important finding discussed in this chapter was that means of depression were highly racialized and sometimes gendered. Many respondents described an environment where depression was viewed as non-existent or not real in Black communities and instead was something that plagued Whites. By using racialized and gendered language to describe depression and the depressed, some were forced not only to contemplate their illnesses, but also their identity as Black American men and women. For them, it was not enough to be “depressed” but they were now also less of a “Black” man or woman. Again, infused in these beliefs were ideas related to strength and the ability to handle adversity due to Blacks’ historical and social past. According to respondents, it was because people from other races lacked this past that they were unable to deal with things and thus became depressed and needed treatment. They also acknowledged that it was ideas like these that delayed their own entry into services and currently keeps many Black Americans who need help from seeking it.

Chapter 3 of the dissertation drew attention to the experience of stigma among Black Americans with depression. It highlighted respondents’ experiences with stigma and how beliefs about depression and individuals with depression operate in Black communities. It also focused on how the experience of stigma is unique among Black Americans. The goal was not to present the idea that that stigma is unique to Black Americans who experience mental health

problems but to show that the *experience* of stigma is unique for Black Americans in a number of key ways.

Many respondents discussed the stigmatizing messages received in Black communities about depression, help-seeking and treatment, including the idea that people with depression as “crazy” and/or “weak.” Like others who experience stigma, these beliefs made it difficult for many respondents to seek help their depression (Alvidrez, Snowden & Kaiser, 2008; Calloway, 2006; Jackson, 2006; Mishra, et al., 2009). Some respondents also shared that they hid their symptoms or the fact that they sought treatment to avoid being labeled and treated differently (Conner, et al., 2010b; Matthews, Corrigan, Smith & Aranda, 2006; Mishra, et al., 2009; Roberts, et al., 2008).

In this chapter, we see again how the negative characteristics of those with depression were often racialized and/or gendered. A number of respondents talked about how being “crazy,” “weak,” or depressed itself were traits of other races, namely Whites and particularly women. The idea that depression was something that did, or should, not affect Blacks was clearly implied if not stated outright. These characterizations of and responses to depression made many respondents feel that depression and treatment were more stigmatized in Black communities. They also shared that talk of depression and treatment was taboo in Black communities, creating feelings of shame in some. The oppressive environment created for many respondents forced some to turn to individuals outside of their family, friends, and community to seek understanding and consolation.

Although some respondents found consultation from individuals outside of Black communities, other respondents discussed fear in having “others” know about their depression. They discussed how non-disclosure was not only about maintaining privacy but also to maintain current positions/statuses. As one respondent stated, she feared she “wouldn’t be taken seriously as a student if it was widely known that I was depressed” while “certain people might be willing to give Suzie White grad student more leeway than they would [her] automatically.” Respondents also talked about a fear of being seen as “different” in their communities and experiencing the loss of key social relationships or disruptions in social networks. The addition of another stigmatizing identity brought fears that they would be further marginalized or lose crucial ground that they have covered socially and professionally. These beliefs support the idea that the impact of stigma could be more detrimental to a person who already endures marginalized status (Bolden & Wicks, 2005; Conner, et al, 2010a; Gary, 2005; Matthews, Corrigan, Smith, & Aranda, 2006).

Respondents also discussed the importance of fighting the stigma experienced and seeking help when needed. Some talked about how they combated stigma at the individual or personal level, but they also expressed the need for community level intervention to educate people about depression and the importance of treatment. Many said that studies like this aided that goal.

Chapter 4 of the dissertation discussed treatment for depression and respondents’ beliefs about how Black Americans view mental health treatment. Respondents not only discussed beliefs held in Black communities about

treatment engagement but also shared alternative methods some Blacks use when dealing with depression. Important in this chapter is the recognition of the role culture plays in shaping health beliefs and behaviors around depression, help-seeking, and treatment including service use. It showed that barriers to mental health service use extend well beyond simple financial and structural factors and involve a web of factors that impact one's engagement in treatment.

Respondents discussed a number of culturally-shaped messages they received about depression, help-seeking and treatment for depression. As highlighted in Chapter 2, many respondents reported that people in Black communities did not view depression as an illness, and those that did, did not believe it was a serious problem (Hines-Martin, Malone, Kim, & Brown-Piper, 2003; Thompson, Bazile, & Akbar, 2004; VanVoorhees, et al., 2005).

Respondents also felt that depression was not seen by Black Americans as an illness that affected their communities. Conversely, some respondents believed that Black Americans felt that life was supposed to be difficult, and thus, depression was something you just dealt with and got over without medical intervention (Anglin, et al., 2008; Barksdale & Molock, 2008; Cruz, et al., 2008; Snowden, 2001; Thompson, Bazile, & Akbar, 2004). In this chapter, we saw more clearly how these two divergent opinions reveal that the term "depression" conveys different meanings to different people. Thus, when one is trying to communicate the presence of a serious problem, their distress may be interpreted as a simple, easily addressed issue. And vice versa. This then complicates how "help" and "treatment" for depression is viewed and dis- or

encouraged.

Some respondents' believed that Black communities were unwilling to acknowledge the depression and instead preferred keeping problems "in-house" and not "air dirty laundry" in therapy. The desire to protect this sensitive information may lay in communities' desire to protect collective identity of Black Americans. Highlighted more extensively in Chapter 3, Blacks have historically been marginalized and stigmatized because of their race; thus, they may not want to add another stigmatizing identity (Bolden & Wicks, 2005; Conner, et al, 2010a; Gary, 2005; Matthews, Corrigan, Smith, & Aranda, 2006). Also, Black Americans pride themselves on being strong and able to deal with adversity (Thompson, Bazile, & Akbar, 2004; USDHHS, 2001). Because some Black Americans see depression as a weakness, they may see the existence of depression in their communities as a threat to the image of Black strength, which could be perceived as a threat to their very existence.

Respondents also spoke at length about the various ways in which help and treatment are viewed in Black communities, with many stating that Black Americans in general were reluctant to engage in more medicalized forms of treatment. They felt that many Blacks were resistant to taking medication and skeptical of therapists, assuming they would be White and not understand their unique experiences, a fact noted by other researchers (Cooper-Patrick, et al., 1997; Cruz, et al., 2008; Duncan, 2003; Thompson, Bazile, & Akbar, 2004). Respondents also discussed how Black Americans placed more belief and hope in other forms of addressing depression rather than professional services.

Prayer, support from friends and family, and positive thinking were all strategies respondents felt Black Americans preferred over formal treatment, not unlike the findings of previous research (Ayalon & Young, 2005; Cooper, et al., 2003; Jackson, 2006; Neighbors, Musick, & Williams, 1998; Snowden, 2001; Taylor, et al., 2000). Respondents did not discourage the use of these methods, particularly prayer and faith, but stated very clearly that this depended on the type or severity of depression. Many believed that these methods should be used only as supports to formal treatment, not substitutions. Again, we saw that there seemed to be a division in how respondents believed depression, and thus treatment, should be defined and addressed and how depression and treatment are viewed socio-culturally in Black communities.

This chapter, too, highlights how messages received about depression and treatment are often racialized and sometimes gendered. Respondents discussed the impression they got that being depressed and/or seeking professional treatment was what “White people talk about” or do. Medical mistrust and racism were largely talked about by male respondents as a reason why more Black Americans do not seek help. These men believed that while culturally-shaped beliefs discourage Black Americans from seeking professional help, past medical care experiences and discriminatory health practices also keep many Blacks out of care.

The impact these messages had on respondents varied, with most respondents stating that these culturally-shaped beliefs had at least some impact on their engagement in treatment, either delaying their engagement in services

or influencing who they shared their depression experiences with. The greatest impact of the culturally-shaped beliefs, as well as the one with the most lingering effect, was on how respondents thought about help and who they spoke with about their distress. Many respondents felt that Black communities were less understanding about depression and treatment and some respondents found the greatest support outside of their communities. Respondents expressed the least amount of impact on how they thought about depression and treatment. These findings reveal that socio-cultural beliefs have the most impact on more socially-oriented health behaviors (help-seeking and discussing their depression with others) and the least on more personally-oriented health behaviors (personal thoughts of depression and personal treatment engagement which is only a type of help-seeking).

Study Limitations and Future Directions

While reflecting on this research process, several thoughts about the study's limitations and future directions of research emerged. First, I realized that this study would have been strengthened by a larger, more representative sample. By increasing and diversifying the sample, we can increase the number of men in the study as well as capture a sample more reflective of the Black population at large. Also, with a larger, more diverse sample, we can look more closely at within-group variations in the beliefs held about Black identity and depression. This study revealed that key gender differences exist in the narratives of depression sufferers, with women focusing more on concepts of

strength and men talking more about mistrust and racism in their treatment experiences. Future study would further explore these differences as well as be sensitive to other demographic differences in experiences. Also, within-group differences have been given less attention in the literature than comparative studies that focus on between-group differences. By focusing on within-group differences, we can create a profile of the Black consumer who are most impacted by various facilitators and barriers to care which will better inform interventions aimed at improving mental health service use for depression within this group.

I also thought about how study participants were allowed to self-identify as having previous experiences with depression and realized how problematic this could be in terms of data analysis. By allowing participants to self-diagnose, I sought to address the issue of losing out on the perspectives of Black Americans who have suffered from depression but have never been diagnosed. Arguably, the bulk of depressed Blacks are those who have had no interaction with mental health professionals and/or services. While the recruitment flyer used language that mental health professionals themselves use to define an episode of depression (feeling sad, empty or depressed for a period of 2 weeks or more during their lifetime), without a proper diagnosis, we are not sure if those who self-diagnosed defined their depression in a way that matched these more clinically-based criteria.

Another important issue that emerged from this study was the realization that the term “depression” can simultaneously hold different meanings in Black

communities. For some, depression may be no more than a response to everyday struggles that can be alleviated through prayer and familial support, but for others, may represent a serious mental health disorder requiring medical treatment. Future studies should more clearly explore the language of distress among respondents and how they, or assume others, define the term depression. Research would also focus more explicitly on the origins of these meanings. In other words, data-gathering instruments would probe how respondents came to understand not only the definition of depression but other health- and treatment-related terms as well. We would then learn more about how “illness” and “help” are conceptualized, shaped, and translated in Black communities.

The focus on language and meaning highlight another area of future research: the language of distress. Many respondents in this study spoke about depression and help-seeking in racialized and sometimes gendered terms. Some respondents talked about depression as something Whites, not Blacks experience, and symptoms like crying were viewing as behaviors of the weak or of White women. While I probed for meaning around these characterizations with some participants, the study was not designed to fully investigate language as a concept with *all* of the participants. Future study would focus on this explicitly. Direct questions about these racialized and gendered ways of understanding depression and treatment would be included in study instruments and reflected in analysis. Origins of such understandings would also be explored as would how respondents personally came to define these ideas. Focusing on

their personal understandings would also distinguish their personal ideas from more communal or familial ways of meaning-making, something that was not always clear in this study.

Another limitation of this study is that beliefs expressed about Black communities were entirely based upon the perceptions of the respondents. The work would have been strengthened by talking with the members of the community who have not experienced depression or other mental health disorders and hearing how they feel about depression, the depressed, and treatment in their own words. I realize that help-seekers' decisions on whether to seek treatment is not based on what Black communities "really" think, but rather respondents' perceptions of community attitudes. However, without the communities' perspectives, we do not know how the help-seekers' beliefs about depression, help-seeking, and treatment develop or if they are truly influenced by the community's thinking. Future research should explore how individuals acquire these beliefs about community attitudes and whether these are critical incidents in which people learn about attitudes toward depression and treatment in Black communities.

Future Directions – Considerations for Intervention Research

As stated in the introduction of this dissertation, throughout the empirical chapters, and at the beginning of this conclusion, this study was conducted with an eye on intervention. As we learn more about how Black Americans think about depression, help-seeking and mental health service use, we can start to

think about interventions aimed at decreasing stigma in Black communities and increasing mental health service utilization rates for individuals with depression. Even though the sample of this study is small and the results are not generalizable to all Black communities, the results from this study have spurred a number of considerations for these types of interventions.

The literature on interventions aimed at reducing mental health stigma in Black communities and educating Black Americans about depression and service use is sparse. However, after an extensive search of the literature, I identified two interventions that target decreasing stigma and increasing service use among Black Americans. The first is a psychoeducational intervention to address stigma in Black adults referred for mental health treatment. The second is a health promotion model that lists key principles to address when designing health promotion programs to use with Black Americans.

Psychoeducational Intervention

An intervention that is used widely in both in anti-stigma campaigns and to inform the public about particular health and treatment concerns is psychoeducation. Alvidrez and colleagues (2009) used a psychoeducational approach to address stigma in Black adults referred for mental health treatment. This randomized pilot study had one group receive existing brochures about services for mental health problems and another received a customized booklet of information of informed by African American consumers addressing information they wish they had known before entering treatment, challenges they

faced and strategies to address such challenges, and advice to others about how to make treatment work for them. The booklets also included consumer quotes. Unfortunately, there were no significant differences between the group receiving brochures and the one received the booklet on treatment adherence. However, for participants who reported the greatest uncertainty about treatment and the highest perceived need for treatment, the receivers of the psychoeducational booklets showed the greater stigma reduction (Alvidrez, et al., 2009). This study shows that stigma about mental health services can be reduced through psychoeducation, but that stigma-reduction alone is not sufficient to increase service utilization.

While this intervention is a good place to start when thinking about interventions targeted at decreasing stigma and increasing service use rates for depression among Black Americans, my dissertation research suggests that there are some additional things to consider. Like the findings of Alvidrez and colleagues (2009), my study also suggests that psychoeducation campaigns may work to increase the service use rates of some individuals with depression. Respondents stated that they believed more Black Americans would engage in treatment if they were better educated on depression and treatment. They also reported feeling that socio-cultural beliefs about depression, help-seeking, and treatment had the least impact on their personal views of depression and engagement in treatment. Thus, psychoeducation interventions aimed at educating Black Americans might overcome socio-cultural barriers at the individual-level and persuade some with depression to seek mental health

services.

However, the study conducted by Alvidrez and colleagues (2009) aimed at evaluating a stigma-reduction intervention was carried out with individuals referred to mental health treatment. It does not offer insight into the impact of such an intervention targeting Black communities at large. When respondents in my dissertation study discussed the impact of socio-cultural beliefs, they expressed that socio-cultural factors still impacted how they engaged in other forms of help-seeking, namely discussing their depression outside of treatment. This finding suggests that learning more about depression and treatment did not make them feel more comfortable talking about their illness with others in their communities. In other words, psychoeducation worked to address personal, internalized stigma and created a path towards seeking treatment, but it neither impacted their fears of public stigma nor did it create a path for more help-seeking within their communities.

Many interventionists believe that these views can be addressed through psychoeducational initiatives. My dissertation work suggests that these interventions may work at the individual-level to increase service use rates but their impact at the community-level, particularly impacting stigma, are still unknown. My study also suggests that interventions must be numerous and multi-focused interventions if they are to be effective.

Health Promotion Intervention

Based on McGuire's (1969) model of persuasive communication, Icard,

Bourjolly & Siddiqui (2003) identified source, message, channel, and target as the four communication variables that must be included when promoting healthy behaviors and encouraged health changes. According to the community, the source of the information communicated must be credible, well-known, trustworthy, and a member of the targeted group. They believe that possessing credentials is not the same as being credible; familiarity with the individuals addressed lends more to being a credible source. Trustworthiness was equated with being able to follow through on making sure the problem highlighted is addressed. The source also needed to be a member of the targeted group and ideally have experienced the problem being targeted (Icard, Bourjolly, & Siddiqui, 2003).

The health promotion model states that the promotional information should be straight-forward, presented in the language of the community, establish a mutual tone, clearly state the benefits of the program, and emphasize and address the concerns of the community. The message should be empowering and indicate how lives will be enhanced. The proper channels for getting the word out about the promotion should be one-on-one, through flyers, or direct mailings. Social gatherings and other community events/activities is another appropriate channel to access. The target of course is the community or demographic of interest in which to deliver the promotion (Icard, Bourjolly, & Siddiqui, 2003).

My dissertation findings also offer insight into health promotion programs like the one described above. I agree that to promote more positive health

behaviors around mental health service use, particularly for depression, that the source of the information should be someone from the community and must be credible. However, my dissertation research suggests that identifying such a person and persuading them to “out” themselves to their community may be difficult. As the findings of my dissertation revealed, many respondents hid their symptoms of depression and/or the fact that they sought treatment to avoid being labeled and treated differently in Black communities. They did not want to be socially isolated or excommunicated for possessing qualities that were seen as non-“Black.” The health promotion model also suggests that the promotion attempted should emphasize and address concerns of the community. This would be a good place to address some of the racialized ideas about depression and treatment as well as the historically-linked ideas about strength.

Looking Forward

The findings of my dissertation work suggest the use of another intervention that has been successful in addressing sensitive and divisive topics: intergroup dialogue. Intergroup dialogue is a multi-and interdisciplinary approach used to explore areas of conflict to improve relations between and within groups as well as to foster social change (Dessel, 2011; Dessel, 2008; Dessel, Rogge, & Garlington, 1996). In facilitated groups, participants discuss topics or issues that have created divisions with the hopes of bringing understanding, resolution, and action (Chasin et al., 1996; Dessel, 2011; Dessel, 2008; Dessel, Rogge, & Garlington, 1996).

Intergroup dialogue would be appropriate to discuss the issues of stigma, social isolation, and support in Black communities around depression. It would bring together individuals diagnosed with depression and community members to discuss not only the feelings of those with depression but the feelings of the community in terms of the challenges that depression and treatment may bring to the image of strength and resolve that are the cornerstone of many Black communities. The idea is to get both sides talking to arrive at a place of understanding, empathy, and support, which can create an environment that is more therapeutic and supportive for Black depression sufferers. The use of intergroup dialogue as an intervention in this area has not been investigated, but based on the definition of intergroup dialogue and the other areas it has been employed suggest that this is an intervention worth trying. This would require more research into the use of intergroup dialogue as well as the designing, implementation and evaluation of its use to address stigma around depression and treatment in Black communities.

Closing Thoughts

It is important that research continue to look beyond financial and structural factors that can impede Black Americans' access to mental health services and take a more culturally-focused approach to better understanding Black Americans' ideas about depression, help-seeking, and treatment. Work should also continue to examine stigma in Black communities, realizing that it can exist in unique ways in various communities and can have varying

repercussions. Recognizing these socio-cultural factors not only gives us a more complete picture of the factors impacting help-seeking and service use for depression, but it offers insight into Black American mental health behavior, particularly how depression is understood and subsequently, how help-seeking and treatment are thought about and approached. Knowing this information can help social workers rethink how we engage with a diverse Black American client population and can assist in the development and implementation of more appropriate interventions to reduce stigma and increase service use for depression among this group.

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Appendix. Data Collection Materials

Clinical Diagnosis Interview Guide

General Depression Questions:

(I am going to ask you some questions about your depression diagnosis)

- When were you first diagnosed with depression?
- Who diagnosed you?
- Did you think you had a problem with depression?
- What was the problem as you saw it?
- What did they recommend as treatment?
- Did you follow the treatment? Why or why not?
- What other things did you do to treat your depression at that time?
- Before you were diagnosed, how did you treat your depression?
- Do you suffer from any other illnesses (physical, mental, etc.)?
- How does this affect your depression?
- How is your other illness affected by the depression?

Episodes Questions

(Now, I am going to ask you some questions about your depressive episodes).

- About how many episodes of depression have you had in the past 2 years? *If they struggle here, ask them how often they were not depressed*
- How many episodes have you had in your lifetime? *If they struggle here, ask them how often they were not depressed*
- How old were you when you had your first depressive episode?
- Do you remember what was going on around the time of the episode (before, during, after)? *If they struggle, give examples: things going on in family, friends, school, work, personally, medically – but then say anything that was going on*

- How about with your other episodes? What was going on around the time they occurred? *If they struggle here, ask them about their most recent episode and then worst episode*
- How about your most recent episode?
- How about your worst episode?

Depression Experience Questions:

(Now, I am going to ask you some questions about your first experience with depression)

- When did you first start to think you were depressed?
- What led you to believe that you were?
- When you first thought you were depressed...
 - Did you tell anyone? Who? Why that person? How did they react? (ask for each person they told)
 - Were there any people that you didn't tell? Who were they? Why didn't you tell them? (ask for each person they mention)
 - Were there any people that you wouldn't tell? Who were they? Why wouldn't you tell them (ask for each person they mention)
 - Were there any people that you wanted to tell but didn't? Who were they? Why did you want to tell them? Why didn't you tell them?
- What about when you were first diagnosed?
 - Did you tell anyone? Who? Why that person? How did they react? (ask for each person they told)
 - Were there any people that you didn't tell? Who were they? Why didn't you tell them? (ask for each person they mention)
 - Were there any people that you wouldn't tell? Who were they? Why wouldn't you tell them (ask for each person they mention)

- Were there any people that you wanted to tell but didn't? Who were they? Why did you want to tell them? Why didn't you tell them?
- What about now?
 - Have you told anyone else that you have/had depression? Who? Why? Why them? Why now?
 - Are there any people that you still *haven't* told? Who? Why not? Why not them?
 - Are there any people that you still *wouldn't* tell? Who? Why not? Why not them?
 - Are there any people that you want to tell but haven't? Who are they? Why do you want to tell them? Why haven't you told them? Do you plan to tell them? Why or why not?
 - How did/do the people who know about your depression treat you? How did they look at you? How did this make you feel? What did you think about it? What did you think about yourself? Did this affect how you looked at depression?(Lots of probing)
 - Are there any differences in how you felt about your depression then and now? Explain.
 - What do you think changed between then and now to spark these differences? Did anything happen to spark these changes?
 - Are there any differences in how others felt about your depression then and now? Explain.
 - What do you think changed between then and now to spark these differences? Did anything happen to spark these changes?

Questions about others with depression:

(Now, I am going to ask you some questions about depression in other people)

- Do you know other people who have had experiences with depression? (If yes, answer the following for each)
 - What is their race?
 - Do you know anything about their experience? Explain.
 - Did they tell people? Who? Who not? Why?

Comparison Questions:

- Do you think your experience with depression is any different than anyone else's? Why and how? Why not or how not?
- Do you think there is a difference between the way black people experience depression and the way people of other races experience it? Explain.

General Black Attitude Questions

(Now I'm going to ask your opinion about some statements about depression and blacks.) How much do you agree or disagree with the following statements (strongly agree, agree, unsure/don't know, disagree, strongly disagree)? How much do you think black people in general agree or disagree? Explain answers.

Statements		SD	D	Uns/DK	A	SA
Black people can deal with anything that comes their way.	Rspdt	1	2	3	4	5
	Others	1	2	3	4	5
Black people do not get depressed.	Rspdt	1	2	3	4	5
	Others	1	2	3	4	5
Depressed people are weak.	Rspdt	1	2	3	4	5
	Others	1	2	3	4	5
Prayer alone is enough to deal with depression.	Rspdt	1	2	3	4	5
	Others	1	2	3	4	5
Depression is a serious illness.	Rspdt	1	2	3	4	5
	Others	1	2	3	4	5
To get better, depressed people only need the support of their family and close friends.	Rspdt	1	2	3	4	5
	Others	1	2	3	4	5
You should see a doctor if you are depressed.	Rspdt	1	2	3	4	5
	Others	1	2	3	4	5
People treat you differently if you are depressed.	Rspdt	1	2	3	4	5
	Others	1	2	3	4	5
All you have to do to treat depression is to think more positively.	Rspdt	1	2	3	4	5
	Others	1	2	3	4	5

- Black people can deal with anything that comes their way.
- Black people do not get depressed.
- Depressed people are weak.
- Prayer alone is enough to deal with depression.
- Depression is a serious illness.
- To get better, depressed people only need the support of their family and close friends.
- You should see a doctor if you are depressed.
- People treat you differently if you are depressed. Ask them to define differently and probe how they were treated differently.
- All you have to do to treat depression is to think more positively.

Do you think there is a difference between how you think about depression and how other black people think about depression? Why? How?

Do you think any of the statements mentioned before or others like them impacted the way you thought about depression? Before your illness? During? After? How? Why?

Do you think statements like those affected the way you looked and asked for help? How? Why?

Do you think statements like those affected those you talked to about depression? How? Why?

Do you think statements like those affected the way you thought about treatment for depression? How? Why?

Demographic Questions

- What is your age?
- What is your race/ethnicity?
- What is your gender?
- What is your occupation?
- What is your highest level of education completed?
- Where did you hear about the study?

Self Diagnosis Interview Guide

General Depression Questions:

(I am going to ask you some questions about your came to believe you had depression)

- When did you first start to think you were depressed?
- What led you to believe that you were?
- Why/how were these things indications to you that there was a problem?
- Did [if answer to above question is criteria related] last for more than two weeks?
- Did someone (a family member, friend, co-worker, pastor, doctor or another individual) tell you that they thought you were depressed?
- Have you seen a doctor, counselor, pastor, mental health care professional for your depression? Why or why not? Did you see someone else? Why or why not?
- Did the doctor, pastor, counselor or mental health care professional recommend some sort of treatment or offer advice on how to deal with your depression? What was it?
- Did you follow the suggestions or recommendations? Why or why not?

Episodes Questions

(Now, I am going to ask you some questions about your depressive episodes).

- About how many episodes of depression have you had in the past 2 years? *If they struggle here, ask them how often they were not depressed*
- How many episodes have you had in your lifetime? *If they struggle here, ask them how often they were not depressed*
- How old were you when you had your first depressive episode?
- Do you remember what was going on around the time of the episode (before, during, after)? *If they struggle, give examples: things going on in family, friends, school, work, personally, medically – but then say anything that was going on*

- How about with your other episodes? What was going on around the time they occurred? *If they struggle here, ask them about their most recent episode and then worst episode*
- How about your most recent episode?
- How about your worst episode?

Depression Experience Questions:

(Now, I am going to ask you some questions about your experience with depression)

- When you first thought you were depressed....
 - Did you tell anyone? Who? Why that person? How did they react? (ask for each person they told)
 - Were there any people that you didn't tell? Who were they? Why didn't you tell them? (ask for each person they mention)
 - Were there any people that you wouldn't tell? Who were they? Why wouldn't you tell them (ask for each person they mention)
- Were there any people that you wanted to tell but didn't? Who were they? Why did you want to tell them? Why didn't you tell them?
- What about now?
 - Have you told anyone else that you have/had depression? Who? Why? Why them? Why now?
 - Are there any people that you still *haven't* told? Who? Why not? Why not them?
 - Are there any people that you still *wouldn't* tell? Who? Why not? Why not them?
 - Are there any people that you want to tell but haven't? Who are they? Why do you want to tell them? Why haven't you told them? Do you plan to tell them? Why or why not?
- How did/do the people who know about your depression treat you? How did they look at you? How did this make you feel? What did you think about it? What did you think about yourself? Did this affect how you looked at depression?(Lots of probing)
- Are there any differences in how you felt about your depression then and now? Explain.

- What do you think changed between then and now to spark these differences? Did anything happen to spark these changes?
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 - Did they tell people? Who? Who not? Why?

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Depressed people are weak.	Rspdt	1	2	3	4	5

	Others	1	2	3	4	5
Prayer alone is enough to deal with depression.	Rspdt	1	2	3	4	5
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	Others	1	2	3	4	5
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- Black people can deal with anything that comes their way.
-
- Black people do not get depressed.
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- Depression is a serious illness.
- To get better, depressed people only need the support of their family and close friends.
- You should see a doctor if you are depressed.
- People treat you differently if you are depressed.
- All you have to do to treat depression is to think more positively.

Do you think there is a difference between how you think about depression and how other black people think about depression? Why? How?

Do you think any of the statements mentioned before or others like them impacted the way you thought about depression? Before your illness? During? After? How? Why?

Do you think statements like those affected the way you looked and asked for help? How? Why?

Do you think statements like those affected those you talked to about depression? How? Why?

Do you think statements like those affected the way you thought about treatment for depression? How? Why?

Demographic Questions

- What is your age?
- What is your race/ethnicity?
- What is your gender?
- What is your occupation?
- What is your highest level of education completed?

Contact Script & Screening

Thank you for calling. My name is Rosalyn Campbell, and I am Joint PhD student in Sociology and Social Work at the University of Michigan. I am conducting a research study on African Americans who have been diagnosed with depression or felt that they may have suffered from depression at some point in their lives. In this research study, I am seeking to interview participants about their past experiences with depression. Through this study, I hope to better understand how African Americans experience depression and how they seek help for the illness. Please understand that participation in this study is not treatment nor will treatment be provided. If you agree to participate, I will interview you at a time and place most convenient for you.

- How did you hear about this study?
- Are you African American/Black?
- Are you at least 18 years old?
- When was your last major experience with depression?
(If currently depressed...I thank you for your interest in this study, but we are looking to speak with people who are not currently experiencing depression. In this study, we will be asking questions about participants' depression experiences, and we do want to cause you further distress. If you are interested, we can supply you with information about depression and resources in your area.)
- Who told you you were depressed? A doctor, pastor, family member, friend, self?

If participants are African American, over the age of 18 and not currently experiencing an episode of depression, they will be scheduled for an interview.