MENTAL HEALTH TREATMENT-SEEKING BEHAVIORS OF AFRICAN AMERICAN WOMEN IN THE SOUTHERN UNITED STATES

by

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ABSTRACT

The purpose of this project was to investigate relationships between religious orientation, stigma regarding mental disorders, and treatment-seeking for mental disorders among African American women in the Southeastern U.S. I hypothesized that religious orientation would be negatively associated with the likelihood that African American women would seek treatment for mental health problems, while controlling for income and other covariates.

To test this hypothesis I conducted interviews with 44 women who have health insurance and whose ethnic identity is African American. Data generated from interview questions about religious beliefs and activity, opinions about mental disorders and mental health care and attitudes of stigma toward mental health problems were used to test the hypothesis. The hypothesis was not supported. However, it was found that the women in the sample were disproportionately depressed, compared to the general population, but were less likely to seek treatment for mild or moderate symptoms. A substantial portion of the sample relied heavily on religious activities such as prayer to cope with depressive symptoms. The results of the analysis indicate that there are unmet mental health needs for African American women, but these needs are largely unrecognized by the women themselves, who appear to have a higher threshold of tolerance for dysphoric emotions relative to women in other ethnic groups. Members of this group may opt not to seek treatment until symptoms are extremely severe and debilitating.

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CONTENTS

LIST OF TABLES

Chapter 1: Introduction

Mental disorders are a serious public health problem in the United States. Mental illnesses such as depression and generalized anxiety disorder can compromise a person's quality of life and strain his or her relationships with key members of his or her social network including family, friends, and colleagues. Those who have depression have higher morbidity than those who do not, and have a shorter life expectancy (Reynolds, Haley, & Kozlenko, 2008). The economic cost of mental illness, measured in terms of resources spent on diagnosis and treatment, as well as lost productivity due to absenteeism, confers a great burden on the public (Lerner & Henke, 2008). Depression is a major risk factor for suicide (Lake, 2008).

Many resources exist to reduce the impact of mental disorders for those affected, including individuals, their households, and the organizations they are involved with. Pharmacotherapy and psychotherapy are frequently utilized, often in combination, to help patients cope with their mental problems. However, in the United States, these therapies can be both expensive, and for some groups, fairly inaccessible (Dwight-Johnson & Lagomasino, 2007). Lack of access to affordable health care is a major problem in the United States. Often insurance plans do not provide the same coverage for mental health as they do for other health treatments. Additionally, millions of Americans lack any type of health insurance coverage.

Access to mental health care can be conceptualized more broadly than simply affordability of care or one's ability to pay for services. There are also social and cultural barriers to seeking care for these problems (Dwight-Johnson & Lagomasino, 2007). Ethnic minorities in

the United States are especially vulnerable to these barriers for a number of complex reasons. It is well known that minorities are underserved in mental health treatment, and are underrepresented in mental health research (Alvidrez, 1999). Additionally, a 2001 Surgeon General's report found that minorities may be more likely than whites to suffer these kinds of problems in the first place.

Moreover, there may be specific ethnic minorities in the United States who are especially underserved by mental health services, such as African Americans (Alim, Charney, & Mellman, 2006). The focus of this project is on African American women in the Southern United States. This group was chosen because it represents a particularly vulnerable segment of American society, one that is continually subjected to ethnic, gender, and often class discrimination.

Research has delved into a number of areas in order to discover the reasons for the existence of the disparities surrounding treatment for mental problems. Studies have found that many African Americans do not trust the mostly white American medical establishment for reasons that stem from a history of unethical treatment (Gamble, 1997). The fact that most African Americans occupy a lower income bracket than whites also contributes to this problem. Additionally, there may be complex cultural reasons for the hesitancy of many people in this group to seek out mainstream formal medical mental health treatment. Research has found that, even when they can afford to pay for it, many African Americans still do not seek mental health treatment at the same rate as whites (Dwight-Johnson & Lagomasino, 2007; Alvidrez, 1999). This implies that, among these persons, there are additional reasons besides economics for why African Americans do not seek mental health care. The major focus of this project was to examine how religiosity and spirituality, important dimensions of culture, are involved in the many different ways that African Americans may conceptualize mental illnesses, their etiologies,

and treatments. Another important component of this project is to explore how religiosity is linked to psychosocial stress, social support, and the stigma that has historically accompanied attitudes of African Americans toward those with mental and emotional instability.

Research in medical anthropology has shown a complex relationship between social inequality, psychosocial stress, mental and physical illness, and adaptive measures taken to reduce the effects of psychosocial stress, such as reliance on social support systems (Dressler, 1991). The group chosen for this project illustrates well this relationship. To cope with these difficulties, many of the women depend on their families, friends, and churches for emotional and material support, and many testify to the calming and healing power of prayer.

This project set out to investigate potential clashes between lay methodologies for coping with mental disorders and the methods and ideologies of the established medical community. Based on an understanding of the history of conflict between black Americans and white medicine, it seems reasonable to conjecture a possible mismatch between the explanatory models of mental illness of Southern African American women and the dominant culture of medical etiologies and clinical treatment. Moreover, the knowledge of the salience of the church as the main institution of social control in African American communities has shaped the direction of this project, the assumption being that adherence to the white medical model of mental illness might be considered deviant by the majority of African Americans.

For this project, I interviewed a total of 48 women in Tuscaloosa, Alabama and surrounding communities. The interviews focused on attitudes and opinions about religion, health care, mental health and mental health treatment, and psychosocial stress. Depression symptoms were evaluated used the CES-D scale. All quantitative data was coded and then analyzed in SPSS v.13.0. The interviews took place between August 2008 and March 2009.

It has been my intention for this research to aid in the understanding of the mental health needs of African American women in the Southern U.S. It is only by approaching this issue from a culturally sensitive perspective that African American women may begin to feel comfortable seeking treatment for problems that are often very personal and painful. A sophisticated understanding of African American women's mental health needs within the context of their cultural understandings about mental health is the best way to develop effective methods of treatment and outreach. This is the spirit in which this research project was designed and conducted.

Chapter 2: Review of Literature

This research project draws from several different academic disciplines including biocultural anthropology, psychiatry, medical sociology, African American studies, and American history. In terms of anthropological theory, this research incorporates political-economic and cognitive approaches. Stress theory also plays an important role.

This research project focuses specifically on African Americans for two main reasons. The first reason is the relative severity of the situation for African Americans, compared to other minority groups. The second is that African Americans are well-represented in the Southern United States because they have long historical and cultural ties to this area. In particular, African Americans have suffered the worst ethnic discrimination in this region, resulting in economic and political deprivation and social marginalization (Johnson, 1996; Du Bois, 1999; Davis, 2000). In complex ways, discrimination is linked with the low rates of treatment for mental disorder seen in this group in this area.

Additionally, there are two reasons why women rather than men were chosen as research participants. First, gender is a potentially confounding variable, thus one gender was chosen to eliminate a possible gender confound. Second, medical research has shown that men seek health care, including care for mental disorders, less often than women (Addis & Mahlik, 2003).

Health Disparities

The major problem that this thesis investigates is the disparity between ethnic minority Americans, specifically African Americans, and European Americans in treatment-seeking for mental disorders (U.S. Department of Health and Human Services, 2001). There is a sizable body of literature documenting mental health disparities, which are part of the larger problem of general health disparities between minorities and whites in the United States. There is a gap between minority groups and whites in virtually every aspect of health, including rates of many different diseases and treatments. In general, African Americans have the worst health of all ethnic groups for nearly every index of health (Dressler, 1993). To illustrate this point, some examples are in order. African Americans have worse birth outcomes than European Americans, including higher rates of pre-term delivery and low birth weight (Oths, Dunn, & Palmer, 2001; Pike, 2005). The life expectancy for blacks is lower than for whites (Lorber & Moore, 2002). Black men in New York City, for example, have close to the same life expectancy as men in Bangladesh, a developing nation (Farmer, 2004). Black women are more likely than white women to contract HIV/AIDS (Lorber & Moore, 2002). Rates of both infectious and chronic diseases are higher for African Americans across all age groups. Symptoms of some chronic diseases begin to show up earlier in African Americans than in European Americans, such as cardiovascular disease (Bibbins-Domingo et al., 2009).

Also, epidemiological studies suggest that African Americans may experience higher rates of mental illness, are less often treated for these problems, and are underrepresented in scientific research for these disorders. Mental health research depicts a complex situation for African Americans. On the one hand, some clinical and community studies have shown that African Americans and European Americans have similar rates of mental illness while others

have actually shown that whites have higher rates of depression and other mental disorders than blacks. On the other hand, there are more African Americans in "high need" populations that are difficult to find or keep track of, such as homeless people or those who live in isolated rural areas (U.S. Department of Health and Human Services, 2001). In fact, there are more than three times as many homeless African Americans as homeless European Americans. Additionally, such high need populations as the homeless have much greater rates of mental disorder. For example, the prevalence of mood disorders may be as high as 30% in the homeless, but is about 8% in the general population. Based on these statistics, it seems reasonable to suggest that there are probably many more African Americans with mental disorders than are currently accounted for (U.S. Department of Health and Human Services, 2001).

Epidemiology and public health research have proposed that health disparities between European Americans and African Americans exist because of genetic reasons, differences in lifestyle choices, or the income gap. None of these reasons adequately elucidate the problem. Rather, a more plausible explanation is that structural forces influence health outcomes because they manipulate social relations in such a way that persons of lower social status experience more psychosocial stress. Since racism is a deeply entrenched problem in the United States, phenotypic features that are associated with different "races" may be more or less valued by society at large. Persons with physical features that are less valued are assigned a lower social status, in the sense that the behavior of others directed toward them indicates to them that they are less valued members of society. The experience of social exclusion or hostility on a continual or chronic basis keeps a lower status individual in a perpetually heightened state of arousal, or stress. The cumulative effects of this kind of chronic psychosocial stress over time result in undesirable health outcomes, such as hypertension and depression (Worthman & Kohrt, 2004;

Dressler, Oths, & Gravlee, 2005; Kuzawa & Sweet, 2009). The relationship between racism, stress and health outcomes will be discussed in more detail below.

Disparities of Treatment

Furthermore, there is evidence that African Americans receive less treatment for mental health problems and are less likely to seek treatment (Sussman, Robins, & Earl, 1987; Alim et al. 2006; Dobalian & Rivers, 2008; Keyes et al., 2008). Some possible explanations for the issue of treatment disparities have also been offered. A major issue for African Americans is the economic barriers to obtaining treatment. Health care in general is expensive in the United States, and millions of Americans have no viable way to pay for it because they do not have health insurance and they do not qualify for government aid for health care. A disproportionate number of African Americans face this situation (Dobalian & Rivers, 2007; Samnaliev, McGovern, & Clark, 2009). Additionally, mental health treatment is often not covered by insurance plans, or is covered in a more limited capacity than treatment for other health problems (Hodgkin, Horgan, Garnick, & Merrick, 2009; Mojtabai, 2009). Cost is a major obstacle for many people who are in need of help for mental disorders.

At the surface, it may appear that this problem is most easily remedied by making efforts to increase access to affordable mental health care. As will be detailed further, the many legal and social changes that have occurred in the last few decades have brought racial equality into the public consciousness, and public health organizations have made valiant efforts to reduce the health outcomes gap between minorities and whites. However, the problem appears to be more complicated. Studies have found that even when income and access are controlled for, minorities still seek treatment at lower rates than whites (Dwight-Johnson & Lagomasino, 2007). Some of

these studies have suggested that there may be complex cultural factors responsible for this situation.

Racism, Stress, and Anthropological Theory

It may seem predictable or obvious that a discussion of racism would appear in this thesis, given that the topic is mental health of African American women. However, the relationships between racism, sexism, classism, access to resources, psychosocial stress, and health outcomes are very complicated. The attempt to disentangle these many problems must begin with a brief discussion of two major theoretical concepts within biocultural medical anthropology – critical medical anthropology and cultural consonance.

The main concern of critical medical anthropology is the relationship between institutional structures of social life and health outcomes (Singer & Clair, 2003). A major tenet of this approach is that health outcomes of both individual persons and social groups are influenced by social forces that are beyond their control. Such social forces are often concrete entities such as national and local governments and their political, economic, and social policies (Farmer, 2005). However, there are other structural processes at work that are more difficult to identify, such as institutional racism. Institutional racism is the sort of racial labeling, ordering, and discrimination that occurs beyond the level of individual belief or action (Santa Ana, 2002). It happens at the cultural level, in the sense that this sort of belief and behavior is internalized at the group level, such that many different entities operate in accord with it. It can be detected in the enormous amount of data that demonstrate both the "income" (in terms of economic resources) and "outcome" (in terms of indices of health) gaps that exist in the United States between the dominant group (European Americans) and the subordinate groups (minorities such

as African Americans) (Farmer, 2005). Examples of such entities that act in accord with institutional racism are the institutions of education, politics, and media. "Institutions" can be defined as social entities that are subject to cultural norms, and are utilized or acted upon by groups of people on a large scale, such as those operating on a regional or national level, and control "discourses" about knowledge and reality (Goffman, 1961; Foucault, 1969; Good & Good, 1993). It is a fact that standardized testing – widely used for college admissions – is biased against black students, who consistently receive lower scores than whites (Cross & Slater, 1997). It is true that there are far fewer African Americans in positions of political influence and leadership than European Americans (Davis, 2000). It is also obvious to anyone who regularly watches television and mainstream films, or reads mainstream print media that the interests and the likenesses of whites are represented far more often than those of blacks (Duke, 2000). By disproportionately representing and serving the interests of one ethnic group over others, these institutions practice racist behavior. As a result, racist beliefs are perpetuated and continue to be internalized and practiced by society at large. Thus, racism, in addition to other social problems, is produced and reproduced on a macroscopic level. It is important to note that other groups of people, such as women, sexual minorities, religious minorities, and the poor, find themselves defined and systematically judged and discriminated against by a very similar process. All groups deemed to be of less importance and who carry less social influence disproportionately suffer worse health than those who wield more power and control.

The second theoretical concept that must be discussed here is cultural consonance. Cultural consonance is the extent to which an individual embodies the cultural knowledge that is shared among members of his or her social group, via culturally salient behaviors or beliefs (Dressler & Bindon, 2000). A person who is measured to have higher cultural consonance is one

whose personal position more closely fits that of the group's cultural model. A person who is said to have less consonance is one whose behavior does not match the model. When the cultural model represents something desired or ideal, having high consonance results in less psychosocial stress, and low consonance results in more stress. When the cultural model represents something disvalued, the opposite is observed, with high consonance resulting in more stress. For example, Dressler, Balieiro, Ribeiro, and Dos Santos (2007) found that persons having high consonance in cynicism about Brazilian national identity experienced greater levels of stress. When people share cultural knowledge about a valued domain, and are able to participate in the activities that it represents, they experience less stress because in doing so they may be accepted socially by the group.

Theoretically speaking, cultural consonance builds upon ideas originating from social psychology about social status and psychosocial stress. Simply stated, psychosocial stress can manifest physically in a number of ways and be measured using a number of biomarkers. An important marker of psychosocial stress is blood pressure because stress causes neuroendocrine chemical changes which interact with the cardiovascular system (McEwen, 1998). The interactions between stressors involved with social interaction, changes in levels of important types of hormones, and cardiovascular outcomes have been observed in humans and animals, including nonhuman primates. The worst outcomes are among those who have both low social status within the overall group and a relative lack of affiliation with other group members of high or low social status (Marmot et al., 1991; Sapolsky, Alberts, & Altmann, 1997). It is possible that both human and nonhuman primates share this biological response to psychosocial stress because of our phylogenetic proximity (Dressler, 2007). It has been only 6 to 8 million years ago since humans and the great apes descended from a common ancestor, evolutionarily a rather short

period of time. Anthropologists' understanding of early humans is that they were highly dependent on each other socially for basic survival (Huss-Ashmore, 2000; Chisholm & Burbank, 2001). Being left out of a group has real health consequences. The rugged individualism of the modern American is not a part of humanity's evolutionary design.

For humans, another marker of psychosocial stress is mood disorders, such as depression. The poor and others who are members of disvalued groups, particularly those lacking social support within their group, are at a higher risk of developing mental disorders in addition to other chronic health problems such as hypertension. This is particularly striking when viewed in the context of economic success. Those who have not achieved their social group's culturally constituted ideal of economic success are found to have higher levels of depression and higher blood pressure than those who have achieved it (Dressler, 1991).

Moreover, social change and changing political policies add another dimension to the mix. When political policies and social norms change, so do people's cultural models. Two important developments have arisen in the last few decades that have changed how people in disadvantaged groups see themselves. The first is the Civil Rights Movement of the 1960s. The end results of the Civil Rights Movement were the granting of voting rights to everyone, the attempt to distribute educational and employment opportunities more fairly, and the belief that every American, white or nonwhite, male or female, should have an equal chance to achieve the American Dream. This belief is deeply internalized among the younger generations of African Americans, such that many blame themselves rather than "the system" when they find their dreams thwarted. This group has been found to display the most dramatic signs of socioeconomically mediated psychosocial stress (Dressler, 1991). A second development that has changed the socioeconomic landscape for millions of minority women is the "welfare

reform" economic policies implemented by the Clinton Administration during the 1990s (Ehrenreich, 2001; Morgen & Maskovsky, 2003). The goal of these policies was to reduce the numbers of Americans receiving federal assistance by providing tax incentives to corporations and businesses to employ people receiving welfare. These jobs usually offered low pay, little opportunity for advancement, and little in the way of job security. "Flexible hours" often meant a widely fluctuating income from week to week. It also meant that those with young children were given unpredictable schedules making it difficult to spend time with their families and difficult to find reliable childcare (Henly, Shaefer, & Waxman, 2006). Most women affected by "welfare reform" experienced a decline in their incomes and overall quality of life. Stress levels, and health problems increased because of the erratic nature of these changes (Martin & Lindsey, 2003; Henly et al. 2006).

In the context of this project, I argue that the systematic exclusion of black women, especially those of lower social distinction as measured by education, occupation, income, and other indicators of cultural capital, by society at large has had a negative effect on their health, which is often successfully buffered by social support. For black Southern women, the most important sources of social support are the church and the family. As I will argue later, conformity to the beliefs and practices of the dominant social group is important because to do otherwise is to risk incurring stigma. I will argue that within this group, a core belief is that mental health is related to one's involvement and standing within one's community, and that the correct way to cope with mental and emotional distress is to rely on one's family and church. The frequently high stress levels experienced by black women who must live in a sexist and racist society are most often managed by being actively involved in their churches and maintaining ties with family members and close friends. I also argue that within this group, an

individual's decision to select a non-normative mode of treatment for mental disorders puts her at risk for social alienation and a loss of needed social support. The relationship between social support and stigma will be detailed further.

Religion and Social Integration

One important aspect of social life is religion. Ever since Durkheim, social scientists have held that religion is integral to social cohesion. Because health is influenced by social integration, and social integration is a major function of religion, recent studies have focused on the link between health and religious involvement (Zullig, Ward, & Horn , 2006). Additionally, the connection between religious belief and emotional security has been investigated. For example, it has been found that people who identify as religious or spiritual report having better physical and mental health, both of which influence their satisfaction with life (Zullig et al. 2006). Spirituality is an important topic to examine. Another study addressing the issue of spirituality among African Americans found that its integration into therapy was more important to this group than it was to the white participants (Cooper, Brown, Vu, Ford, & Powe, 2001).

African Americans often turn to their clergy when experiencing mental health problems (Brown, 2004). For this reason, researchers have focused on the function of pastoral counseling in minority communities and have determined that clergy can contribute valuable knowledge about their parishioners' needs to health professionals (Young, Griffith, & Williams, 2003). Clearly, religion is an important component of social integration and social support for the African American community, many of whose members may prefer to seek help for psychological distress from their religious leaders rather than physicians or therapists.

A recent study focused on the relationship between religious involvement and treatment-seeking of mental health care (Harris, Edlund, & Larson, 2006). It was suggested that parishioners with serious mental illness are often referred to health professionals by clergy; however those with milder problems are not as likely to seek professional help. Next, I will elucidate another important reason why biomedicine may not be the most favored form of treatment for mental health problems among African American women.

Mistrust of Medicine

An important factor in the disparity in treatment seeking for mental disorders may be that many minorities, especially African Americans, fear and mistrust the biomedical health care establishment. There are compelling reasons for African Americans to feel uneasy in the presence of medical doctors. The mistreatment of black patients by white doctors is best exemplified by the infamous Tuskeegee Syphilis Experiment, in which African American men were, without their knowledge and consent, deliberately denied treatment during advanced stages of syphilis in order to scientifically document its progression (Gamble, 1997). It is very doubtful that such unethical experimentation would ever have been conducted on middle class white men. Knowledge of these experiments has traveled all over the world, even half a world away in AIDS stricken Zimbabwe. Black Zimbabweans with AIDS fear modern medical treatment by white doctors for precisely the same reasons as many black Americans: because of past medical abuses of black people by white physicians (Rodlach, 2006).

Additionally, ethnic discrimination has plagued psychiatry in particular. Early in the nineteenth century, various hypotheses circulated in the psychiatric literature about racial origins of mental illness. Throughout the century, medical opinion vacillated between two ideas. The

first was the notion that blacks and other non-whites were free from mental disturbances because they were unaffected by the stressors of civilization which caused so many whites to experience mental and emotional disorders. The implication was that non-whites were not civilized enough to experience mental illness. The second was the opinion that racial inferiority caused mental problems. Although data from that time demonstrates that the increasing rates of mental problems among African Americans occurred along with the social unrest following emancipation and its resultant diaspora of former slaves, racist physicians preferred to perpetuate the idea that non-whites were fundamentally intellectually and mentally deficient (Prudhomme & Musto, 1973). Thus, psychiatric opinion was slow to discard the racism and ethnocentrism of the pre-Civil War era. Today, African Americans' fears of psychiatric medicine persist. In particular African Americans continue to express fear of being institutionalized and being prescribed harmful medications (Richman et al., 2007; Schnittker, 2001).

The Civil Rights Movement has made a deep impact on medical ethics, helping bring attention to racial discrimination such as that found in the Tuskegee Syphilis Experiment, and physicians have tried hard to assure their minority patients that their intentions are ethical. For example, today informed consent is required before performing any medicine procedure or doing any kind of medical research. Such changes were a response to the racism and exploitation that characterized the way that medicine was practiced before the Civil Rights Movement (Pence, 2007). Today, many black patients will see a physician for physical ailments but still hesitate to ask them questions about mood disorders such as depression or anxiety. It has been thought that the stigma surrounding mental illness that has long existed in the black community may contribute to black patients' reluctance to discuss these problems with health care professionals and to seek treatment (Caldwell, 2003). Stigma attached to those with mental illness is not

exclusive to African Americans, but it may be an important barrier to treatment for this group for complex social, cultural, and economic reasons (Anglin, Link, & Phelan, 2006). For a long time, African Americans as a group have been vulnerable to discrimination when applying for employment, housing, education, and other necessities. The burden of having a mental disorder, or being associated with another person having one, only adds to the difficulty of obtaining basic needs in an already hostile social situation. In other words, institutional racism interacts with the stigma regarding mental illness as a feedback loop, with mental illness intensifying racism and racism perpetuating both mental illness and the stigma associated with it.

Social Support and Stigma

Social integration, psychosocial stress, and health are strongly connected to each other. As I have already explained, high levels of psychosocial stress are associated with poor health, and the effects of stress can be buffered with social support. Depression, along with blood pressure, is one of many useful biomarkers of psychosocial stress in humans. Persons who experience chronic stress, resulting from low social status within a large social group, such as a state society, or within a small social group, such as one's own community, generally experience worse health, including mental health (Cannon, 1942; Hollingshead & Relich, 1958; Cassel 1976). Chronic stress can lead to serious mental disorders such as major depression. Persons undergoing chronic stress who rely on a stable support network as a way to cope with stress usually experience better mental health than those who do not have this kind of social support (Dennis, Markey, Johnston, Vander Wal, & Artinian, 2008). Social support may take the form of emotional solidarity or instrumental assistance, such as help with finances, childcare, or other everyday matters.

However, one must be able to integrate into a community fairly successfully in order to find and keep a social support network. Those who are not able to integrate, perhaps because they are perceived as deviant, have considerable difficulty building these kinds of relationships (Pescosolido, 2008). Traditional community based support networks, such as those revolving around church and family, depend upon a certain level of social homogeneity. People must be like each other in order to understand, value, and support one another. To stay securely positioned within a social network, one must conform to its rules and norms by doing what others deem to be appropriate. If a person does not conform to the rules of the social group, he or she risks being stigmatized. If for African American women in the South conformity means relying primarily on one's family and church for emotional support it may be difficult to seek other avenues and to act according to other norms. In other words, seeing a psychiatrist or going to a therapist may be thought to be non-normative in the African American community. Women who wish to rely primarily on their traditional support networks may be reluctant to seek outside help if it is possible that her decision could be disclosed to someone inside that network.

Mental Illness, Social Stigma and Religion

African Americans may be more likely than European Americans to stigmatize mental disorders (Anglin et al., 2006). Stigmatization may include both public stigma, which is an attitude that the general public has toward the mentally ill, and self-stigma, which is the internalized public stigma that a mentally ill person directs toward him- or herself (Corrigan & Watson, 2007). It is suggested that mentally ill African Americans are particularly prone to experiencing both types of stigma. The most common negative perceptions about the mentally ill are that they are dangerous or that they are to blame for their condition because it is a sign of

personal weakness or the result of bad decisions (Anglin et al., 2006). Additionally, research has shown that African Americans may conceptualize mental health in more spiritual or religious terms than European Americans. Moreover, African Americans may prefer that spirituality be integrated into counseling therapy (King, Burgess, Akinyela, Counts-Spring, & Parker, 2005; Cooper et al., 2001).

In the Southern United States, religious participation is nearly mandatory for members of the African American community. It is unusual to find an African American in the South who is not religious and does not attend religious activities. For instance, a 1987 Gallup Poll found that about 78 percent of the African American population regularly attended church (Lincoln & Mamiya, 1990). In these communities there is a positive association between frequency of prayer and Bible study and depressive symptoms. It has been suggested that these populations may use prayer as a substitute for formal mental health treatment when experiencing high levels of personal stress (Ellison, 1995). A possible reason for this is the stigma attached to mental illness and the affected individual's reluctance to allow others to know he is seeking formal mental health treatment.

Explanatory Models of Mental Disorder

It may seem that the mental health inequalities, including disparities in rates of treatment, experienced by African Americans could be eliminated if public health promotion efforts could successfully educate African Americans about mental health and convince them that mental disorders should be treated with conventional biomedicine. However, whether or not it is true that mainstream psychiatry is the best way to treat these problems, the difficulty of convincing minority groups that it is the most efficacious treatment simply illustrates the fact that there are

diverse ways in which different groups of people conceptualize various diseases, illnesses, and disorders (Kleinman, Eisenberg, & Good, 1978; Schieffelin, 1985). In other words, health problems are shaped culturally and socially, and so are the ways in which people understand health problems and the ways they deal with them. It is important that health care professionals understand the diversity of ways that different groups, including ethnic minorities, understand illness. An explanatory model, or folk model, is a culturally informed framework by which a person understands the cause, course, and treatment of a health problem (Kleinman et al. 1978). Although there is individual variability in explanatory models, they are always conditioned by the cultural models that his or her social groups hold. For example, in middle-class white American society, the explanatory model for the common cold is that it is caused by germs that are transmitted by an infected person, that the person will experience certain symptoms such coughing, that the symptoms should last no longer than a couple of weeks and that a person with a cold needs plenty of rest and fluids. This model is highly influenced by the biomedical model, which is based on the germ theory of disease (Payer, 1988). In other words, the folk or explanatory model in most of white middle class American society of the common cold is the biomedical model. Folk models among this particular social group of many other ailments also mirror the biomedical model. However, there are other social groups, including many ethnic minority groups such as many African Americans, whose explanatory models of some ailments differ from the biomedical or white middle class models.

In the case of mental illnesses, the prevailing biomedical understanding is that they are caused by abnormal chemical interactions in a person's brain. For example, depression is thought to be influenced by neurotransmitters called serotonin. When there is not enough serotonin in the synapse, a person may become depressed. This understanding of depression seems to have

grown out of research on how antidepressant medications work (Fabrega, 1982; Good, Good, & Moradi, 1985; Nutt, 2008). However, the fact that some people with depression often do not respond to these medications, or require different types of treatment in conjunction with them, demonstrates that purely biochemical explanations for depression are incomplete (Morishita & Aoki, 1999).

As discussed previously, there are also explanations for depression that come out of social psychology and stress theory. These explanations involve the biochemistry of stress hormones, but they also take into account the social, emotional, and cultural influences on levels of stress hormones in an individual's body (Brown & Harris, 1978). Stress hormones, such as corticosteroids, are involved in complex interactions with other hormones and neurotransmitters and these interactions in turn affect a person's neurochemistry. In other words, the stress process can set off a chain of events leading to depression in some individuals. Social psychologists have found that, for individuals experiencing high levels of psychosocial stress, the effects of stress hormones on the body and mind are mitigated by social support, most often in the form of emotional support. Persons lacking the emotional support of family, friends, and community are more likely to become depressed in certain situations (Brown & Harris, 1978). These include both acute stressful events such as a death in the family or the birth of a child, or chronic stressors such as social exclusion or having a job which puts multiple demands on a person without allowing that person much control over how to accomplish tasks or how to conduct one's personal business, such as taking short breaks (Karasek, Baker, Marxer, Ahlbom, & Theorell, 1981; Oths et al., 2001; Tstusumi, Kayaba, Ojima, Ishikawa, & Kawakami, 2007). In either case, these situations and their meanings are shaped by the cultural ideals and models of the society in which a person lives (Dressler et al. 2007). Cultural models are then internalized

by individuals and made into a personal version of that model, which is also shaped by personal experiences and interpretations of the dominant cultural model. This is how culture is "downloaded" into individual persons (Romney, Welder, & Batchelder, 1986; D'Andrade, 1995; Goodenough, 1996). As explained earlier, cognitive theories such as cultural consonance have developed methods to analyze cultural models and how well individuals may be able to conform to them (Dressler et al., 2007).

Because there are many different societies and subcultures, and each has different cultural models about how to live, there are multiple ways of understanding health and illness. Some illnesses are even culturally specific, in that they only occur within certain groups because they revolve around the cultural meanings of those groups. A classic example within biocultural medical anthropology is the Latin American *susto*, or "fright illness" (Rubel, 1964). Yet, even health problems that affect virtually all populations will vary with each group, and different groups understand their health problems within their own cultural context. Depression is a good example of a disorder that may be present in nearly all populations on a biological level, but which presents with culturally specific symptoms (Good et al., 1985; Gaines & Farmer, 1986). Though there has been intense debate on whether depression, as well as most other psychiatric disorders, really exists cross-culturally, presenting with key physiological symptoms and having a generally biological etiology, many anthropologists now believe that such a possibility is so. However, it is also generally acknowledged that depression, as biological a problem as it may be, does in fact pattern itself differently within varying populations (Gaines & Farmer, 1986).

For example, in North America and Western Europe, depression is usually experienced as a profoundly distressing psychological disorder. Americans and Europeans with depression usually experience intense dejection, self-blame, and even self-hatred. However, in non-Western

societies such as China, what Western doctors diagnose as depression (and Chinese doctors may diagnose as neurasthenia) is primarily experienced as a physical disorder characterized by insomnia, lethargy, pain, and dizziness (Kleinman & Kleinman, 1985). It may be said that non-Westerners somatize and Westerners psychologize. Knowing this, it is quite probable that a Chinese patient may display symptoms that a Western doctor may not recognize as characteristic of depression, simply because the "classic" Western psychological symptoms are not present. Yet, therapies that are familiar to the doctor may work for the patient if the etiology of the symptoms is the same for both the "Western" and "non-Western" symptoms. If the cause of the patient's symptoms was not determined, the patient could come away from this experience lacking an accurate diagnosis and efficacious treatment. Thus, it is unhelpful, and even dangerous, for health care providers to limit their understanding of medicine to Western patterns of disease and illness and their correspondingly Western-centric modes of treatment, especially in the case of mental health disorders.

It has been noted in the now extensive body of literature on culture and mental illness that conceptions of the self may be an important part of how mental health is understood by different cultural groups (Lutz, 1985; Johnson, 1998). In Western society, the prevailing cultural understanding of the self is that each person is an independent, bounded individual who is capable of change, improvement, and progress. People are thought to determine their own futures by harnessing their own potential, by working hard and exerting their will. In non-Western societies the self may be thought of in more collective terms, such that each person is part of a larger group that possesses enduring qualities or character traits that are unlikely to change because they exemplify the "nature" of the group (Gaines, 1982). Persons belonging to these groups personally possess the same attributes that characterize the group. Of course, these two

frameworks are not mutually exclusive. For example, part of the collective identity of mainstream Americans is that Americans are highly individualistic (Ohnuki-Tierney, 1984). The difference in conceptualizing the self in individualistic rather than collectivist terms may explain why European Americans are more likely to seek treatment for a variety of medical issues, including mental health problems.

In sum, African American women in the South are a cultural group (which in fact is composed of a number of even smaller subgroups), and it makes sense that they would have their own cultural models about what depression and other mental disorders are, what causes them, and how to treat them. It would probably be most helpful for biomedical health professionals to understand these models and work with them, rather than try to "correct" them with culturally inappropriate treatments and diagnoses (Nelson, 2006). It is useful to learn the explanatory models for the ailments which affect these groups of people. It is important to understand the socioeconomic conditions that affect African American women, and to learn about the structure of their communities, and the realities of their lives. These elements actively shape how African-American women experience and think about their mental and emotional health. Finally, it is instructive to acknowledge what African American women currently do to cope with emotional distress, especially when such coping methods are successful. It may prove to be particularly useful to incorporate elements of these strategies into treatments and outreach efforts that are specially designed to address the needs of this specific group (Young et al., 2003).

New Questions and Research

As mentioned previously, this research project draws on research from many different areas of study. What is missing from most studies on this topic is a holistic, ethnographic

perspective of a problem affecting an American social group. Most research on mental illness within the United States is not anthropological and does not utilize qualitative methods, which are needed in order to analyze quantitative data within an appropriate context (Quimby, 2006). Alternately, most of the anthropological research on mental illness takes place outside the United States, and while cross-cultural research is useful for comparative purposes, the population investigated here in more detail is situated locally. It seems reasonable to use anthropological theory and method to analyze a problem of American origin. Moreover, a mixed methods approach is holistic, which is important because anthropology researches everything about the human species and considers it all in a broad perspective. Such a process has yielded startling insights into the human experience. I wanted to do the same with this particular topic.

Additionally, this project synthesizes a number of key biocultural concepts into a case study. Many times a few concepts appear in one study or another, but often in a rather fragmentary way. These ideas can work together to deliver more satisfying analyses and conclusions. In this thesis, I argue that mental illness is, for many African Americans, conceptualized as directly resulting from impiety, that is, a lack of faith or spirituality, or a lack of connection to one's religious community. Whether or not this is true, community connection and social support are vitally important resources for a group that has long suffered ethnic, gender, and class discrimination, which has resulted in serious inequalities in health outcomes. I also argue that the benefits of social support, such as improved mental health, hinge on social conformity, which in this context refers to reliance on religion and spirituality for emotional well-being. Therefore, when a person experiencing emotional distress or mental instability turns to resources outside the religious network, there is a risk of alienating his or her primary network of social support, which would result in further diminished well-being. It is for this reason that I

have hypothesized that people who rely most on a religious community for social support, that is, those who are most religious, are less likely than those who are less religious to seek out formal psychiatric treatment for mental disorders.

Chapter 3: Setting and Methods

For this project, all data was collected in West Alabama and East Mississippi between August 2008 and March 2009. It was decided from the beginning that overtly religious or medical settings be avoided as places of data collection in order to reduce the risk of selection bias. Instead, respondents were recruited from local places of employment.

I developed the research instrument by combining questions taken from the literature and questions that I generated from numerous unstructured interviews and informal conversations with colleagues, health care providers, and clergy. In many cases I altered the wording of interview questions that I took from other research studies to ensure that it was culturally appropriate and well understood by the respondents. For example, a question taken from the Intrinsic Religious Motivation Scale was altered to use simpler language (Hoge, 1972). The question from the scale, "Quite often I have been keenly aware of the presence of God or of the Divine Being", was changed to "I have had powerful spiritual experiences in my life." As part of this process, I pre-tested the initial interview schedule with four respondents and used their feedback to omit and add questions, and to reword other questions. This was a useful way to refine the interview schedule.

Work Sites

As mentioned, all of the respondents were recruited from local places of employment. This was done in order to avoid selection bias because the objective of the project was to ascertain the opinions about mental health treatment from typical African American women in the vicinity of West Alabama, rather than those with specialized knowledge of health care or religion. It should be noted that although religious participation is extremely common among this population, my research design depended upon interviewing women varying in religious orientation and participation. Since I would be unlikely to find, for example, a non-religious person in a church, I did not try to recruit respondents from religious settings.

It was immediately clear that it would be impossible to gain access to employees of large companies having a multiregional, national, or international presence, such as large retail companies. Instead, I opted to contact local businesses such as small manufacturers and municipal employers. The women interviewed for this project were all recruited from these types of businesses.

Additionally, it was challenging to find local businesses that offered health insurance to all of their employees. The research design required that all respondents have insurance benefits in order to control for lack of insurance as a deterrent to seeking treatment. Many local small businesses simply cannot pay for insurance for all of their employees. Some of the small businesses I contacted were interesting in working with me on this project, but they did not offer insurance to all of their employees. Unfortunately, most large companies that can afford to offer most of their employees insurance did not respond to my attempts to contact them. Finally, after several months of searching, I found two private companies and one municipality from which to

recruit participants. One company also has a location in Eastern Mississippi in addition to West Alabama, and I conducted several interviews there.

Initially, my plan was to conduct each interview in either the respondent's or my own home. I conducted about one third of the interviews in this manner. It became clear that many respondents, though interested in participating in the interviews, did not have the resources to meet me outside of work. Many of these women live far from where they work and by the time that they would get home it would be late into the evening. Also, their weekends were often busy caring for children and grandchildren. I was fortunate enough to be allowed by one company to conduct interviews on site and during employees' shifts. I conducted about two thirds of the interviews on site. No open-ended interviews were conducted on site. Instead, all of these were structured interviews, and several of them included free-listing.

Description of the Sample

This research used a static two-group comparison design. The project required at least 40 respondents. All respondents were required to be women whose ethnic identity is African American and who have health insurance. The respondents were to be between the ages of 35 and 65. All but five of the respondents were over the age of 34. This age requirement was chosen primarily to avoid very young women because many young people have not yet fully formed their religious orientation (Trinitapoli, 2007). Half of the sample needed to be classified as "less religious" and the other half needed to be "more religious".

A total of 48 women were interviewed for this project. Each respondent has health insurance and identifies as African American. They range in age from 29 to 64. The first four interviews were conducted for the purpose of pre-testing the research instrument. I have included

these women's responses to the free-listing questions and the open-ended questions, but they were not included for the main data set, which is composed of responses from the other 44 women to the final interview schedule. These 44 women completed the structured survey. Twenty-six of the 44 also completed the free-listing portion of the interview. These 26 women plus the four women who participated in the pre-test comprise the 30 responses to the free-listing questions.

I recruited respondents in a number of different ways. I began by contacting non-academic departments of the University of Alabama and several local businesses. One University of Alabama employee contacted me for an interview. She had received a letter that I had written explaining the details of the study, and which I had given 120 copies of to the supervisors in one non-academic division of the University. The human relations manager for one local manufacturing company sent 109 letters to female employees informing them of the study. I drafted the letter which detailed the purpose of the study and the eligibility requirements. As I also did for the University employees, I emphasized that participation in the study was voluntary and unaffiliated with the company. Several interested employees contacted me by phone or e-mail to set up interviews. All six of these interviews took place at either the respondent's or my own home. The human relations manager for a local municipality sent information about the study to female employees via e-mail and several women contacted me for interviews. These interviews also took place at their homes, except one which was conducted at a public library. Most of interviews in which I traveled to the respondents' homes were located in or near Tuscaloosa. The furthest I traveled was about 30 miles south of Tuscaloosa for one interview at a participant's home. A third of the interviews came from these work sites. These women were paid $5 and given a home-made bath gift.

The remainder of the interviews, about two thirds, took place at two local food processing plants. The family of a friend of my husband owns the company. Our friend put me in contact with the human resources manager at the corporate office, who referred me to the plant manager at the local plant. The plant manager and I agreed that I come to the plant during the lunch break and introduce myself to employees and tell them about the study. By introducing myself personally and giving everyone home-made cookies I got an enthusiastic response and many women signed up to be interviewed. Moreover, the plant manager allowed me to conduct the interviews on site at the plant and during the employees' shifts. I conducted 13 interviews at the West Alabama plant and 17 interviews at the East Mississippi plant. I was referred to the plant manager at the Mississippi plant because the supervisors at the Alabama plant were having difficulty coordinating interviews without slowing production. The women at the processing plants were paid $5 at the time of the interview and given a home-made gift.

At the Alabama plant, interviews were conducted in a variety of locations within the plant, including a conference room, nurse's station, and a small office. At the Mississippi plant, all interviews were conducted at a semi-secluded table in the break room, located away from the other tables. Since the interviews were not conducted during the respondents' break times, there were usually few others present in the break room, which was fairly spacious to begin with. Moreover, when others were present they generally kept their distance from the table where the interviews took place. For this reason, sensitive information elicited during the interviews was not heard by others. In this way, the interviews took place in a reasonably private location. It should be noted that before commencing each interview, I asked the respondent if she would prefer that the interview take place in another location, such as a table outside the building. None

of the respondents indicated a preference, so all interviews took place inside the building in the break room.

At both plants, the entrance led directly into the break area. In both plants, the break areas had concrete floors with booths and tables riveted to the floor. The booths and tables were made of a hard plastic material. The break rooms also had lockers where employees could store personal belongings and vending machines where they could purchase drinks, sandwiches, snacks, and medicine. There were also several microwaves where employees could heat food they brought from home. Smoking was allowed in break room area of the plant, but only in that area. There were small rectangular metal ashtrays on the tables. I noticed more employees smoking at the Alabama plant than at the Mississippi plant. At times the smoke was so heavy that it made my eyes burn. In both plants there were swinging double doors that led into the production area. At the Alabama plant, the human resources office was accessible only by walking through the doors into the production area and walking past the production line. The concrete floor in the corridor leading to the human resources and nurse's office was always wet with water and a sanitizing solution. I had to walk carefully to avoid slipping on the floor. The Mississippi plant's layout was slightly different. The human resources office and nurse's station were accessed directly from the break area so that it was not necessary to enter the production area to get to them.

Though I had not originally planned to conduct interviews at the plants or in Mississippi, the opportunity to do so proved instructive. Though it was not participant-observation in the traditional sense, because I did not work on the production line, by going to the plants I was able to get a much more realistic picture of everyday life for these women. The supervisors at the Mississippi location gave me a complete tour of the plant. Both plants looked clean and safe to

work in. However, the work itself that I observed is repetitious and physically demanding. A number of the women told me about their injuries that occurred on the job, mostly repetitive stress injuries in addition to small cuts on the hands and arms. Moreover, the plants were very cold and there was a lot of ambient noise from the machines used in production. All employees wore disposable earplugs connected by a plastic cord that could rest behind the neck when not in use. They also wore gloves, rubber aprons, rubber boots, and hairnets. When I toured the plant in Mississippi, I wore a hairnet myself.

Additionally, by traveling to a rural community in Mississippi, I really got a sense of the isolation and poverty experienced by many of these women in their everyday lives. By describing the community as isolated, I do not mean to imply that the members of the community do not know each other well but rather I emphasize the geographic isolation from city life and its conveniences, including top quality medical care. I did not see a medical clinic in the entire town. I asked many of the women where they went to the doctor or did their shopping. Many of them said that they have to travel more than 30 miles to the nearest community that is large enough to have clinics. Some of the women said that they sometimes travel as far as Tuscaloosa for shopping or medical care.

The Interviews

As mentioned, the interviews consisted of three parts. The first part was a structured survey which collected data on demographics, religious orientation, social interaction, opinions about health care, mental health, and treatment, and a screening tool used to diagnose depression. All respondents answered the structured interview questions. The second part consisted of free-listing questions, designed to gather knowledge in three cultural domains: diagnoses of mental

disorders, etiology of mental disorders, and treatment for mental disorders. Although this project does not include consensus analysis, I wanted to get an idea of the sample's knowledge of these topics. Most respondents participated in the free-listing section of the interview. The third part was the semi-structured, or open-ended, interview. The open-ended interviews asked a number of questions about experiences and opinions about religion and spirituality as well as mental health and general health care. All names used in this document are pseudonyms. These questions were designed to allow the respondent to speak at length about these topics. About a quarter of the respondents took part in the semi-structured interviews. Each woman gave her informed consent to be interviewed. I read each participant a consent form, which I then asked her to sign and date, if she was willing to take part in the interview. Each participant was given a copy of the consent form with my contact information, which I also signed. I highlighted my phone number and name because some of the participants were not able to read. I conducted all of the interviews.

I developed the interview schedule after doing an extensive literature search on the research question. I read articles about religiosity and spirituality, African Americans' experiences with health care, and many aspects of mental health including stigma, cultural influences on mental health, and cultural variation in how mental illnesses are understood and treated. I engaged in numerous conversations with health care providers, clergy and churchgoers, and my own colleagues about these topics and how to ask the right questions during the interviews. The interview schedule eventually included questions which were designed to determine the respondents' religious orientation, hypothetical inclination toward treatment-seeking, explanatory models of mental disorders, experiences with racism in medical settings, and levels of personal stress and social interaction. Most of the questions in the structured

interview schedule used a modified Likert scale, ranging from 1 (total agreement) to 4 (total disagreement). For example, one question that measures religiosity was: “I do not feel like I have a close relationship with others at my church”.

There were also two questions that asked the respondent to rate their preferences in treatment-seeking for general illness and in speaking to a trusted person about mental health problems. For example, choices for the latter question included family members, friends, clergy, or health care professionals. I used laminated cards for the responses, which I read to the respondent as I gave them to her. I then asked the respondent to arrange the cards in order of most preferred to least preferred. The depression scale was included to determine if a participant may have depressive symptoms. This was done to ascertain if there was any effect of depression on participants’ opinions about mental health. The demographic questions that were collected concerned age, marital status, number of children, income, and household composition. See Appendix A for the complete interview schedule.

Statistical Tests

Following the completion of the data collection, I began preliminary analysis to determine the religious orientation of the respondents. First, it must be pointed out that, although religious orientation is ultimately operationalized as a dichotomous variable, there is actually a continuum of religiosity and spirituality. For the purpose of the project, I wanted to separate the sample into two groups of “more” religious and “less” religious, rather than “religious” and “non-religious”. In order to dichotomize the sample into high and low religiosity, I reverse coded the positive questions (those phrased in the affirmative, for example: “I practice my religion about as often as most other people I know”) and then summed the responses, for a possible

range of 17-38. Then I divided the sample at the midpoint, yielding two approximately equal groups.

The continuous variable for religious orientation is a sum of scores of each of the following variables: religious practice, spirituality affects happiness, spiritual experiences, divine intervention, close relationship with others at church, and church's approval of behavior. The first three variables were reverse coded because they were asked in the affirmative, as explained above. See Appendix A for the full questions in the interview schedule.

The same process was utilized for other summed variables such as attitudes of stigma toward mental illness and persons having mental illness, social interaction, and the likelihood of seeking medical treatment for mental health problems. For example, one question used to detect stigma was: "It is better to stay away from mentally ill people". Another was: "Mentally ill people are dangerous." When used for regression analysis, these composite variables were not dichotomized unless the distributions were not normal. They were dichotomized into low and high values when the distributions were non-normal or when using the chi-square test for association.

The continuous stigma variable was a sum of scores of each of the following variables: mentally ill people are dangerous, mental illness is caused by sin, mental illness is caused by making bad choices, it is better to stay away from mentally ill people, many immoral people have mental problems, it is possible to get addicted to medications for mental health problems, mentally ill people need support to get better, telling friends about mental health problems, telling employer about mental health problems, talking to family about mental health problems, talking to pastor about mental health problems, and talking to friends about mental health problems. The first six questions were reverse coded because they were asked in the positive.

The latter three were rated from most to least preferred out of a set of choices about preferred persons to talk to about mental health problems. For the full questions in the interview schedule, see Appendix A.

The continuous social interaction variable is the sum of number of children, marital status (coded 1 = not married, 2 = married), frequency of getting help with personal problems (coded 1 = low, 2 = high), and whether the informant lived alone or with others (coded 1 = alone, 2 = not alone) (see Appendix A). The continuous likelihood of treatment-seeking variable was a sum of scores for each of the following variables: seeing a counselor, seeing a doctor, taking medication, believing that mental health problems are natural diseases, believing that mentally ill people can get better by seeing a counselor, believing that mental health problems can be treated with medication, seeing a doctor, going to the emergency room, and seeing an alternative medicine healer if ill, talking to a doctor about mental health problems, doctors visits, trusting doctors, and believing that white doctors take their African American patients seriously. See Appendix A.

Responses to individual questions which used the four-point Likert scale were also summed and dichotomized into low and high. In this way, two by two crosstabs (chi-square) can be used to test for associations between religiosity and inclination toward treatment-seeking, bias against persons having mental disorders, mistrust of medical settings, personal stress, and explanatory models of mental disorders.

Correlations are used for continuous variables having a normal distribution. These include the scores from the CES-D scale, income, and the composite variable of religiosity. Correlations were run between these variables and also between these variables and dichotomous variables. For example, a correlation was run between mistrust of doctors, which is a

dichotomous variable, and income. If an association was found with a chi-square test, but not with a correlation, I checked a scatter-plot diagram to see if there were unusual distributions. For example, an association was found with a chi-square test between income and depression when both variables were dichotomized. However, it was not found with a correlation when the variables were continuous. After checking the scatter-plot, it was found to have a slightly curvilinear shape, although most of the data points were concentrated on the left side. For this reason, I chose to dichotomize these variables and use the results of the chi-square test. I also looked at scatter-plots to check the linearity of correlations in general.

For multiple regression analysis the dependent variable is the likelihood of treatment seeking for mental disorders. Covariates were selected by testing for correlations between the dependent variable and the variables that were used to create the composite variables discussed earlier. The linear regression includes the dependent variable as well as the covariates of income and age, standard covariates, and religious orientation, the main predictor variable in this project's hypothesis. A multiple linear regression was calculated to test an additional hypothesis that stigma regarding mental health problems can be predicted by certain beliefs, such as the preference for a religious doctor and adherence to the beliefs that such disorders are natural diseases and are caused by problems in society.

Chapter 4: Qualitative Analysis

In order to complete an analysis of the qualitative data gathered for this project, it is necessary first to consider some background pertaining to the subject population, including the history of the population and its relationship to the broader history of the geographic region, as well as its relationships to religion and mental health. These topics will briefly be reviewed alongside my own ethnographic observations and narratives constructed by the research participants.

African American Women in the Southern United States

In a broad sense, the stories of the women I interviewed begin almost four hundred years ago, when the first enslaved persons from Africa were brought to North America. For more than two hundred years, the South relied on slave labor to reap profit from the land (Rogers, Ward, Atkins, & Flint, 1994). Today, the largest concentration of the descendents of these people live in what is now called the Black Belt. Originally, the Black Belt referred to the rich dark soil of the geographic area which forms a crescent shaped path through Mississippi, Alabama, and Georgia, upon which the Southern cotton industry was founded. Since modern times, when cotton ceased to be the dominant money maker of the region, the name of this region was appropriated to refer to the large concentration of African Americans who live there (Lincoln & Mamiya, 1990).

Consequently, the Black Belt region now extends beyond its traditional boundaries to encompass all of the counties of the Southern states in which the majority of the population is African American, from portions of Texas in the west all the way to Virginia in the east (Wimberley & Morris, 1997). However, the fact that the name originally referred to the land is important, because the physical characteristics of the land are the reason for its current demographic composition. The Black Belt region is mostly populated by the descendents of the slaves who worked the fields before the Civil War, and after, under the institution of sharecropping. This region, as well as many predominantly African American communities outside of it, continues to be plagued by economic underdevelopment and its resultant poverty and the problems resulting from poverty, such as poor health (Calhoun, Reeder, & Bagi, 2000). A number of the participants interviewed for this project reside in counties of the Alabama Black Belt, including Hale, Greene, and Pickens, as well as the Mississippi Black Belt, including Noxubee County.

After the Civil War, African Americans were nominally free and ostensibly equal to whites in the eyes of the law. However, in practice, African Americans continued to be subjugated by economic and legal provisions which made it possible for whites to control the political landscape, segregate the major social institutions, and deny African Americans the basic rights of education, property ownership, and suffrage (Rogers et al., 1994). The Jim Crow laws were responsible for officially sanctioning this inequality. The system of sharecropping ensured economic inequality in praxis, by condemning sharecroppers to an endless cycle of debt to their white landlords and making it extremely difficult for their children to complete their public education (Johnson, 1934). The promises of freedom and prosperity that followed the end of the

Civil War proved to be hollow into the following century. It was not until the Civil Rights Movement that real change began to occur for African Americans in the South.

Even today, the disparities that exist between whites and blacks, in terms of health outcomes, education, and political and economic power, are disturbingly great. Val, the nurse at one of the processing plants where I conducted interviews, estimated that at least 40 percent of the employees who work at the plant are at least functionally illiterate. According to the Tuscaloosa News, one out of five adults in Tuscaloosa Country is functionally illiterate and the rate is even higher in Greene County at just over one half (Avant, 2008). Val, the nurse, said that this problem, coupled with the lack of trust that many of the African American employees have in medicine, as well as the management at the plant, makes it difficult for her to communicate with them, in spite of the fact that she herself is African American. While I was sitting with her in her office, a young man walked in, took off his boots and apron and headed for the door. It was his first day on the job. Val asked him what had happened. He said that the supervisor told him to leave because he was too slow on the production line. Val knew it was it was the man's first day and she asked him if he had asked the supervisor if there was something else he could do instead. The man shook his head and she told him to wait there, and then called the plant manager. She then directed him to the manager and told him that the manager would talk to him about trying another task. After the young man left, Val said:

> See what I mean? They don't communicate. He was just about to leave on the first day! I deal with this sort of thing a lot. Like the time that we started offering direct deposit for those debit cards that you can use instead of cash. It was for their convenience and safety, so they don't have carry around a lot of cash, because a lot of them don't have bank accounts. They didn't trust us; they thought they wouldn't get their money.

I asked Val why the employees did not trust her or the management. She said:

> Because they've been done wrong, taken advantage of. You know, when you don't know how to read, you can't defend yourself. You're at a disadvantage. And so these things have happened to them and they don't trust anyone. And they don't want anyone to know. See, when you need to have them sign something, they say something like 'I don't have my glasses today, I'll sign it tomorrow'. And you know they don't wear glasses because you never seen them wear glasses before. They're embarrassed about it and can't ask for help.

It is difficult to argue that these systems of inequality have been more difficult for black women than for black men because both genders have experienced extreme hardship and cruelty at the hands of the dominant majority. But it is true that both genders experienced, and continue to experience, unique difficulties and challenges. Because this project focuses on women, their struggles will be spotlighted. However, black men's problems are intimately intertwined with women's and sometimes male-specific problems need to be addressed to obtain a more complete understanding of the predicaments specifically affecting black women.

During the pre-Civil War era, two serious problems affecting enslaved women were their roles in caring for white children and their sexual subjugation to white men (Smith, 1994). In caring for white children, they were often taken away from their roles as mothers to their own children. The very institution of slavery often separated families - wives from husbands, parents from children, grandparents from grandchildren (Rogers et al., 1994). By being forced to submit to sexual relations with their white masters, they gave birth to children who were not allowed to interact with their fathers and white siblings (Smith, 1994). The subservient position that black men held in relation to white men hampered their ability to conform to white cultural models of masculinity (Brown & Keith, 2003). Consequently, African American gender relations were fundamentally different from those of European Americans. Largely absent from black families was the emphasis that whites held on nuclear families controlled by men who dominated the women and children. The resulting situation was that women held more responsibility for

disciplining children and contributing materially to the family's livelihood. It has been argued that this family dynamic persists today in the form of the so-called "black matriarchy" in which men are often virtually absent from the household and the raising of children (Sharpe, 2001; Frazier, 1939). Thus, by not possessing the dominant culture's ideal model of masculinity, which is that of economic provider for the family, African American men have often turned to illegal activity in a primarily homosocial environment, removed from the business of marriage and active fatherhood (Tucker, 2003; Sharpe, 2005). Recently, there has been some debate concerning the effects on African American women of being married or single. While some African American women have claimed that this configuration has allowed them to be more independent than European American women, both financially and socially, others have argued that this kind of social organization is at least partly responsible for the general difficulty that the African American population has had in achieving economic, political, and social parity with European Americans (Brown, 2003).

The entire dynamic of black-white relations at the time of slavery was violent, coercive, and traumatic. Slaves had to endure grueling physical labor throughout the entire year. They were routinely punished with physical violence, often for no clear reason. Their living conditions were horrendous. They lived in cramped, substandard housing with as many as ten people living in tiny one room cabins. Clothing was shabby and medical care was inadequate. Education and literacy were forbidden (Blassingame, 1979). They were given the discarded scraps of food that whites would not eat, such as the tops of turnip plants and the entrails of pigs. Such foods were creatively combined with other ingredients to make up traditional dishes that are still prepared today as part of the popular cuisine called soul food (Tillery, 1996). And although the end of the Civil War abolished slavery and made it legal for African Americans to buy land and get an

education, very similar conditions characterized life as sharecroppers and tenant farmers throughout much of the 20th century (Johnson, 1934). It was a very hard life that was survived by dint of creativity, tenacity, intelligence, and a strong reliance on faith and community. These are traits of African American culture that live on today.

Religion and African American Women

The importance of the role of religion for African Americans, in the past and the present, cannot be overstated. For centuries, the black church has been the only institution that is owned and managed solely by African Americans. For African Americans, the church was always more than just a church. It was the center of social life, the arts and music, education, political advocacy and action, and economic development (Lincoln & Mamiya, 1990). It was the only place where black people could freely engage in social and cultural activity.

Perhaps most importantly, the church provided African Americans comfort in a hostile world and hope for a better life in the hereafter. The stories of the Bible resonated with their own experiences as an enslaved and oppressed people. The exodus of the Hebrews from slavery in Egypt was interpreted as strikingly parallel to their own plight (Smith, 1995). The message was that, as children of God, they were worthy of liberation and that in time it would come. The message and example of Christ was also inspirational. It reminded them that they were valued and loved by God, a deity who was especially sympathetic to the plight of the poor and disempowered (Smith, 1995). Christian faith enabled African Americans to survive centuries of inhumane treatment and to maintain, as a people, the self-respect that is necessary for such survival. In the absence of earthly justice, it was the steadfast belief in a just God that made it possible for African Americans to rise against the tyranny of Jim Crow and launch the Civil

Rights Movement, which was pivotal in improving many of their lives (Lincoln & Mamiya, 1990). Today the church is still the cornerstone of communities of African Americans all across the U.S. Indeed, a local clergyman confirmed that it would be very difficult for me to find any informants who were not religious: "Everyone you're gonna talk to will be faithful. You might find someone who is a Muslim or a Buddhist or something like that. But they'll all believe in *something*. Maybe you could find some that aren't religious in prison. But not anywhere else." The pastor proved to be correct. The black church is so important in the South that I did not speak to a single African American woman during the entire course of my research who did not have some involvement with the Christian faith. In fact, a 1988 study found the highest rate, 85 percent, of religious participation in the nation among African Americans in the rural South (Nelsen, 1988).

Time and again, the participants in the study described their faith as encompassing their entire lives. They described their faith as inspiring them to persevere through difficulty and they said that prayer alleviated anxiety. Some of the women had experienced traumatic events and said that prayer and faith helped them to survive. Tessa said: "I guess you could say I depend on [God]. I used to be a worry-wart, but not anymore. Sometimes you have to let go and let God. God plays a very extensive role in my life."

Tessa's mother-in-law and sister-in-law died when a tornado ripped through their home. She was pregnant at the time, and had been experiencing a lot of stress and anxiety. She also was the one who had to call her husband's brother to tell him what had happened. Tessa's mother was there with her when she was about to have a panic attack, but her mother reminded her to pray. Tessa told me that the act of prayer relieved her panic and made it possible to calmly tell her brother-in-law that his mother and sister were dead.

> Respondent: She said that I needed to pray with her. And I felt a calm. Before that I was frantic, upset, crying. You know, just a flood of emotion, but after I prayed, I actually felt a calm.
>
> Interviewer: So the experience of prayer sort of got you through this situation so you could calm down and deal with it.
>
> R: Right. Because initially I was not, until my mother brought that to my…I would say that she brought it to my attention. That, you know, that's when you need to pray the most.

Another respondent, Shelly, had been in an abusive marriage with a man who regularly beat and raped her. She and her former husband had been separated for about six months. She was home one night when her cousin called and invited her over to her house. Shelly was tired from working that day and wanted to relax at home but her cousin called her again so she decided to go. She found out the next day that her husband had murdered three people. He had a list of victims and Shelly was next on the list. The night that Shelly went to visit her cousin, her husband had come to her house to kill her. Because she was not at home, he moved down the list and killed two other people before being apprehended. Shelly told me that she was certain that if she had not gone to visit her cousin, she would not have lived to tell me this story. I asked her what she did to cope through this difficult time. "Prayer. Prayer. A couple of friends, but they were not there the whole time, sometimes they weren't available and…just praying. Praying to God to keep my sanity. Because I almost lost it. I really did." I also asked Shelly how she feels when she prays. What she said was remarkably similar to what others said:

> I feel a calm assurance when I pray. I feel like everything is going to be all right. And I pray all the time, all through the day, whether things are going good or things are going bad. I feel like if I pray when things are good, maybe when they're bad they won't be so bad. You know, because I've already sent up the prayers and I can reach back and get some of those.

Prayer was the element of religion that was most often mentioned by the women I interviewed. Many of them said they pray every day, all throughout the day. One woman said:

"You know when you say 'Lord, have mercy!', well, that's a prayer. And I say that one a lot. I pray when I go to bed, when I get up, when I'm on my way to work, while I'm on the [production] line…just all the time. It gets you through the day." Frequently, prayer was described as a spontaneous practice. The women said that they pray when happy, to express their joy and thanks to God. They also said that they pray when feeling stress, sadness, and frustration. Numerous times I heard the phrase "let go and let God". It was explained as a way to relieve themselves of some of the tremendous stress that accompanies the responsibilities that go along with their social roles as mothers, daughters, sisters, wives, and employees. To let go of their need to control the uncontrollable was a way for them to handle conflict in their lives without disrupting harmony in social relationships. I interpret this to mean that turning stress over to God is a way of deflecting responsibility so that they do not have to feel guilt over not always trying to be all things to all people.

Chapter 5: Quantitative Analysis

Descriptive Statistics

The entire sample of 44 participants is female, and self-identified as African American. All informants have some type of employer-provided health insurance benefits. Although 48 women were interviewed in total, 4 of them were interviewed during the pre-testing phase of research, thus the quantitative data from these informants are not included in the final quantitative analysis.

The mean age of the sample is 45.6 years and the standard deviation is 8.9 years. The youngest age is 29 and the oldest is 64. The mean yearly income is $32, 800 and the standard deviation is $18, 200. The minimum yearly income is $10,000 and the maximum is $90,000, which yields a range of $80,000 per year.

All but four women in the sample have children. The mean number of children is 2.1 and the standard deviation is 1.24. The minimum number of children reported is zero and the maximum is five. The distribution of all variables in Table 5.1 is normal.

Table 5.1 Descriptive Statistics of Sample

	N	Mean	SD[2]	Minimum	Maximum
Age	44	45.6	8.9	29	64
Income	44	32,800	18,200	10,000	90,000
Number of children	44	2.1	1.2	0	5
Depressive symptoms	42	12.8	8.6	0	35
Religious orientation	44	32	4.3	17	38
Social interaction	44	8.6	1.8	5	13
Stigma	30	28.3	4.6	21	37
Treatment seeking	30	46.2	6.5	31	58

Twenty-one informants (47.7%) are married or in a stable, long-term, cohabiting relationship. Twelve (27.3%) were divorced or separated at the time of the interview. Ten (22.7%) were single, had never been married, and were not living with a long-term partner. Just one informant told me that she was widowed.

The reported frequencies of religious activities are high, as was expected. The majority of the sample, 19 informants (43.2%), attends church services once a week. Thirteen (29.5%) informants attend church more than once a week. Nine women (20.5%) go to church about twice a month, and only three women (6.8%) went to church less often than that. None of the informants said that they never attend church. The majority of the sample, 33 women (75%) they pray more than once a day. Only nine (20.45%) informants pray once a day and just two (4.5%) pray once a week. Bible study was also commonly practiced. The most commonly reported frequency of reading the Bible was once a day (34.1%). Ten participants (22.7%) read the Bible once a week and another ten (22.7%) do so just once in a while. At the extremes, seven women

(15.9%) read the Bible more than once a day and just two women (4.5%) never read the Bible. Religious orientation ranged from 17 to 38, with a mean of 32 and a standard deviation of 4.3.

Table 5.2 Descriptive Statistics of Religious Orientation (%)

	N	>once a week	Once a week	Twice a month	Once a month	A few times a year	Never
Church attendance	44	29.5	43.2	20.5	2.6	4.2	0

	N	>once a day	Once a day	Once a week	Once in a while	Never
Prayer	44	75	20.5	4.6	0	0
Reading Bible	44	15.9	34.1	22.7	22.7	4.5

	N	Strongly agree	Agree	Disagree	Strongly disagree
Religious practice	44	61.4	18.2	11.4	9.1
Spiritual happy	44	81.8	11.4	4.5	2.3
Spiritual experiences	44	59.1	27.3	11.4	2.3
Divine intervention †	44	84.1	4.5	9.1	2.3
Relationships at church †	44	63.6	13.6	11.4	11.4
Church's approval †	44	38.6	9.1	20.5	31.8

† -- reverse coded

Health measures include depression level, experiencing personal stress, frequency of outside help with personal problems, and frequency of doctor's visits. Forty-two informants were screened for depressive symptoms using the Center for Epidemiological Studies Depression Scale (CES-D). The range of scores is 0 to 60. The mean score is 12.8 and the standard deviation is 8.55 with a range of 0 to 35. One third of the sample had scores that were above 15, high

enough to be screened as clinically depressed. Two-thirds of the sample reported that they sometimes feel more stress than they can handle, however 77.3 percent said that they can always or usually count on someone they know for help with personal problems. The mean number of doctor visits is 3.2 per year and the standard deviation is 2.1, with a range of one to 15.

Scores for religious orientation, social support, stigma, and the likelihood of treatment seeking were calculated by summing the individual variables denoting these topics which were originally measured on a four-point Likert scale. Variables that were phrased in the affirmative were reverse coded. This was done so that the values for the continuous variables would be higher for high agreement and lower for low agreement. Originally, the Likert scale was designed so that total agreement was coded as 1 and total disagreement was coded as 4. The scores were dichotomized at the median into high and low values for use in bivariate analyses. These were used as continuous variables for correlations and regression.

Social interaction was measured on 44 participants with a range of five to 13, a mean of 8.6, and standard deviation of 1.8. Stigma was measured on 30 participants with a range of 21 to 37, a mean of 28.3, and standard deviation of 4.6. The outcome variable for regression analysis was the likelihood of treatment seeking for mental disorders. It was measured on 30 participants with a range of 31 to 58 points, mean of 46.2, and standard deviation of 6.5.

Table 5.3 Descriptive Statistics of Sample

	N	**Married %**	**Unmarried %**
Marital status	44	52.3	47.7
	N	**Yes**	**No**
More stress than can handle yourself	44	65.9	34.1
Clinically depressed	42	33.3	66.7

	N	High	Low
Frequency of outside help	44	77.3	22.7
	N	**<Three per year**	**≥Three per year**
Doctor visits	44	59.5	40.5

Bivariate Analysis

Chi-square tests (two-by-two crosstabs) were used with categorical variables. They were used to detect associations between religious orientation and mistrust of doctors and the medical establishment, attitudes of stigma toward mental illness and persons having mental illness, and beliefs about etiology of and treatment for mental illnesses. When the expected count was less than five for one or more of the cells in the crosstabs, the Fisher's exact test was used. The same tests were used to find associations between other key variables of income and depressive symptoms, mistrust, stigma, and beliefs about etiology and treatment. The alpha level was set at .05. All tests were two-tailed. Correlations were used to find associations between religious orientation, depression, income, and stigma.

Religious Orientation

There was a significant inverse correlation found between religious orientation and depression ($r = -.311$, $p = .045$) and a weakly significant positive correlation found between religious orientation and age ($r = .270$, $p = .076$) There were no significant associations found between religious orientation and mistrust of the medical establishment. However, there was a significant positive association found between religious orientation and the belief that prayer could cure mental disorders ($\chi^2 = 6.343$, $df = 1$, Fisher's exact test, $p = .022$). All of the high

religiosity participants agreed that prayer could cure mental disorders, but only 73.9 percent (17 out of 23) of the low religiosity participants agreed with this statement.

There were also notable, though not significant, trends regarding some variables denoting attitudes of stigma toward mental disorders and those having mental disorders, as well as some variables denoting beliefs about etiology of and treatment for mental disorders.

First, regarding stigma, the majority in both the high and low religiosity groups thought that people with mental disorders are dangerous. However, a greater proportion of the high religiosity group agreed with this statement. Of the high religiosity respondents, 73.7 percent agreed that persons having mental illness are dangerous compared to 65.2 percent of the low religiosity respondents. Additionally, a greater proportion of the high religiosity group, 61.1 percent, agreed that mental problems could be caused by making bad choices while only 43.5 percent of the low religiosity respondents thought so.

Surprisingly, although the majority in both groups disagreed that mental illness is the result of sinful behavior, a higher proportion of low religiosity respondents agreed with this statement. Of the 20 high religiosity participants who responded to this question, only six (30%) agreed, compared to nine (39.1%) of the low religiosity participants. Additionally, more of the high (66.7%) than the low religiosity participants (52.2%) said they would tell a friend if they were having trouble with their mental health.

Second, there were also a couple of trends detected regarding beliefs about the etiology of mental disorders. More than two thirds (17 of 23) of the low religiosity participants agreed that family problems could cause mental problems, but only slightly more than half (11 of 20) of the high religiosity participants did so. Also, 89.5 percent (17 of 19) of the high religiosity

participants thought that bad life experiences could cause mental illness, compared to 78.3 percent (18 of 23) of the low religiosity participants.

Third, there were two notable trends concerning beliefs about treatment for mental disorders. As mentioned, there was indeed a significant association between religiosity and the belief that prayer could cure mental illnesses. All of the high religiosity informants agreed that God could cure mental illnesses directly, while three of the low religiosity informants (13%) disagreed with this statement. Additionally, though the majority of both groups agreed that their health care decisions were *not* influenced by their religious beliefs, a greater proportion of the low religiosity informants (78.3%) than the high religiosity informants (57.1%) thought so.

Finally, it should be noted that there were neither any significant associations nor any striking trends between religiosity and many other variables that measure mistrust of medicine, stigma surrounding mental illness, or beliefs about psychiatric etiology and treatment. For example, the majority of both the high and low religiosity groups agreed that they would see a doctor and a counselor if they felt they were having trouble with their mental health. Neither group was more likely to say that mentally ill people should be avoided or that mentally ill people need the support of others to get well. Additionally, the majority of both groups said they would take prescribed medication for mental problems and that medications can effectively treat these problems, but also that they thought that it was possible that such medications were habit forming. The majority of both groups also felt that elements of spirituality should be included in therapy, but that it did not matter if the therapist or physician personally was religious.

Associations between Key Independent Variables

In addition to religious orientation, income level and depressed mood were tested for associations with the variables measuring mistrust, stigma, etiology, and treatment. Because these are ancillary independent variables, only significant associations will be included here.

For depression, there was a significant negative association between income level and depression ($r = -.365$, $p = .017$). Additionally, there was a significant negative association between the belief that doctors and therapists want to help their African American patients and depression ($r = -.384$, $p = .013$).

Regarding income level, there was a significant negative association with mistrust of doctors ($r = -.310$, $p = .040$). There was a weakly significant positive association between income level and health care decisions not being influenced by religious beliefs ($\chi^2 = 3.772$, $df = 1$, $p = .052$). A greater proportion of the high income participants (81.8%, 18 of 22) said that their religious beliefs did *not* influence their decisions about health care. However, only 54.5 percent (12 of 22) of the low income participants agreed that religion did not influence their health care decisions.

Table 5.4 Associations with Religious Orientation

	N	**r**	**χ^2**	**Fisher's exact test**	**High group (%)**	**Low group (%)**	**P-value**
Depressed mood	42	-.311					.045**
Age	44	.270					.076***
Income	44	-.081					.60
Stigma	31	-.049					.794
Prayer can cure	44			✔	100.0	73.9	.022 *
Dangerous	44		.349		73.7	65.2	.555

	N	r	χ^2	Fisher's exact test	High group (%)	Low group (%)	P-value
Bad choices	43		1.257		61.1	43.5	.262
Sin	44		.393		30.0	39.1	.531
Tell friend	44		.945		66.7	52.2	.329
Family problems	44		1.685		55.0	73.9	.194
Bad experiences	43			✔	89.5	78.2	.428
God can cure	43			✔	100.0	87.0	.329
Religion influences health decisions	44		2.257		57.1 (d)	78.3 (d)	.133
See doctor	44			✔	95.7	95.2	1.000
See counselor	44			✔	80.0	87.0	.687
Should avoid mentally ill people	44		.273		28.6	21.7	.601
Mentally ill people need support	44			✔	95.2	100.0	.477
Taking medication	44			✔	85.7	82.6	1.000
Medication can be addictive	44			✔	93.8	86.4	.624
Therapy should have spirituality	44			✔	85.7	82.6	1.000
Prefer religious doctor	44		.220		52.2	47.8	.639

(d) -- percentage indicates disagreement

Table 5.5 Associations with Key Variables

	Depression (CES-D scale)	
	r	**p-value**
Help black patients†	-.384	.013**
Income	-.365	.017**
	Income (Yearly)	
	r	**p-value**
Mistrust†	-.310	.040**
Religion influences health decisions† d	**χ^2**	**p-value**
	3.772	.052*

(† -- Dichotomous variables coded 0 = low, 1 = high, d = indicates disagreement with question)

Table 5.6 Bivariate Correlations of Likelihood of Treatment-Seeking for Mental Health Problems with Various Predictors

	r	**p-value**
Age	.056	.768
Income	.191	.312
Religious orientation	-.064	.745
Depression	-.189	.334
Stigma	.243	.242
Influence of religion on health decisions†	.047	.807
Prefer religious doctor†	-.308	.104
Mental disorders caused by society†	.150	.427
God can cure mental disorders†	-.058	.766
Prayer can cure mental disorders†	-.208	.270

(† -- Dichotomous variables coded 0 = low, 1 = high)

Table 5.6 is a correlation matrix showing the dependent variable, treatment-seeking for mental health problems, and relevant covariates. Age and income are standard covariates. Religious orientation is the variable of interest in the hypothesis. Depression, stigma, influence of religion on health care, preference for a religious doctor, and the beliefs that mental illnesses are caused by social problems and can be cured by God and with prayer concern beliefs about etiology and treatment for mental health problems and also serve as variables for alternative hypotheses. The first four variables in the table are continuous. The latter five are dichotomous variables. None of the covariates in Table 5.6 are significant.

Table 5.7 Bivariate Correlations of Stigma toward Mental Health Problems with Various Predictors

	r	**p-value**
Family problems	.464	.009**
Bad life experiences	.410	.022**
Natural diseases	.357	.034**
Caused by society	.530	.002***
Caused by stress	.459	.009**
Prefer religious doctor †	.414	.023**
Influence of religion on health decisions	-.346	.057*

† - dichotomous variable coded 0 = low, 1 = high

All others Likert scale coded 1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree

A correlation matrix for an additional dependent variable, stigma toward mental health problems, is shown in Table 5.7. The first five variables represent beliefs about the etiology of mental disorders while the latter two variables refer to beliefs and preferences about treatment. All the variables are significantly positively correlated with stigma toward mental disorders

except for religion's influence on health care, which is weakly inversely correlated with stigma (r = -346, p = .057). Also, stigma is positively correlated with the belief that mental health problems are caused by problems in society (r = .539, p = .002) at the .005 level. All are dichotomous variables except for mental health problems being caused by society and religion's influence on health care decisions.

Multiple Regression Analysis

Multiple regression analysis was used to determine if the likelihood of seeking medical treatment for mental disorders could be predicted based on religious orientation, with the standard covariates of income and age also entered. The regression was not significant (F(3, 26 = .478, p = .701) with an R^2 of .052.

Table 5.8 Multiple Regression of Likelihood of Treatment-Seeking for Mental Health Problems and Covariates

	Unstandardized coefficient	**p-value**
Constant	45.109	.000
Age	.062	.658
Income	.075	.284
Religiosity	-1.820	.578

*p<.05

Table 5.9 Multiple Regression of Attitudes of Stigma toward Mental Health Problems and Covariates

	Unstandardized coefficient	**p-value**
Constant	19.559	.000
Caused by society	1.876*	.011
Natural diseases	.955*	.240
Prefer religious doctor†	3.899*	.006

*p<.05, † - dichotomous variable coded 0 = low, 1 = high

A linear regression was also calculated to test an additional hypothesis that stigma concerning mental disorders could be predicted by adherence to certain beliefs. This regression had attitudes of stigma as the dependent variable, predicted by the beliefs that mental disorders are caused by society and are natural diseases as well as the preference for a religious doctor (see Table 5.7 above).

Table 5.9 shows the covariates used in the regression of which two are significant, the preference for a religious doctor and the belief that mental disorders are caused by problems in society. The regression was significant ($F(3, 26 = 8.212, p = .001$). R^2 is .487, thus 49 percent of the variability in the dependent variable is accounted for in the regression.

Summary of Findings

The likelihood of treatment-seeking for mental disorders is not predicted by religious orientation, income, or age. The beliefs that mental disorders are caused by social problems and the preference for a religious doctor predict stigma toward mental disorder. Both covariates are directly correlated with stigma.

There were no significant associations found between the religious orientation and mistrust, stigma, beliefs about etiology and treatment, age, or income level. However, there were a number of striking trends and two significant associations relating to religious orientation. First, religious orientation was moderately and inversely correlated with depression ($r = -.311$, $p = .045$). Second, high religiosity participants were significantly more likely to believe that prayer can cure mental illness ($\chi^2 = 6.343$, $df = 1$, Fisher's exact test, $p = .022$). However, there was no significant association between religious orientation and the belief that God could cure mental illness ($\chi^2 = 2.669$, $df = 1$, Fisher's exact test = .239, $p = .239$). On the surface, this may seem strange. But the belief that God can cure illness and the belief that prayer can cure illness are two different things. During the open-ended interviews, some participants said that they believed that God works miracles through medical science, but that even though prayer can boost an ill person's morale, it alone cannot *cure* illness. However, more traditionally religious participants did express belief in "laying on of hands". This practice works in concert with faith and prayer to cure sick people. Moreover, the fact that respondents who are more religious were less likely to have more depressive symptoms confirms numerous other studies that have shown that religious belief and participation are protective against depression and other mental health problems (Jang & Johnson, 2004; Corrigan & Watson, 2003; Ellison, 1995). In fact, religious activity and belief may play an important role in the self-management of chronic health problems such as depression (Harvey & Silverman, 2007).

Other notable trends were that a slightly lower proportion of low religiosity respondents said that mentally ill people are dangerous and that mental problems are caused by an individual making bad choices. However, a slightly greater proportion of high religiosity respondents reported that they would tell a friend if they were experiencing mental distress and disagreed that

mental illness was connected with sinful behavior. Also, a greater proportion of low religiosity respondents thought that mental disorders could be caused by problems with family dynamics but a greater proportion of high religiosity respondents thought that traumatic life experiences could cause mental illness. However, these trends were not significant.

Less surprising, there were significant negative associations between income level and mistrust of physicians ($r = -.310$, $p = .040$) and depression ($r = -.365$, $p = .017$). Additionally, there was a weakly significant negative association between income and the influence of religion on health care decisions ($\chi^2 = 3.772$, $df = 1$, $p = .052$). There was also a significant negative association between depressed mood and the belief that doctors want to help their African American patients ($r = -.384$, $p = .013$). The hypothesis, that religious orientation affects treatment-seeking for mental disorders, was not supported. Indeed, the data gathered from this sample indicate that religion has little effect on how the respondents conceptualize mental illness or what actions they take when confronted with these kinds of problems. For example, the majority of both the high and low religiosity groups felt that mentally ill people were dangerous. Furthermore, both groups were equally likely to see doctors and counselors and to take medications if they felt they were experiencing mental distress. And although both groups were likely to utilize formal health care for these problems, both groups were equally likely to be concerned that psychiatric medications are addictive.

A few interesting observations can be gleaned from these data. The belief in prayer as a cure for mental illness is associated with how religious the informant is. Likewise, income is connected to the influence of religion on health care decisions. For those with higher incomes, religion is less influential in guiding health care decisions than it is for those with lower incomes. Moreover, income is significantly inversely associated with mistrust in doctors and with

depression. Furthermore, depressed informants were more likely to believe that doctors do not really want to help them because they are African American. It may be that lower income African American women with depression are more likely to turn to religion, especially prayer, to cope with their distress. Indeed, there is a moderate inverse correlation between religiosity and depression for this sample ($r = -.311$, $p = .022$). Perhaps depressive symptoms are minimized by engaging in religious activity. But regardless of this effect, one third of the sample was screened as clinically depressed. This proportion is more than double the estimated lifetime prevalence for the general adult population in the U.S. of 16 percent (Givens, Houston, Van Voorhees, Ford, & Cooper, 2007).

The African American women represented by this sample may be a vulnerable group that is indeed difficult for the psychiatric community to reach because they do not trust medicine and do not want anyone to know about their suffering. Therefore, they rely on themselves and their faith to cope with their illness. This also fits with the cultural ideals of strength and stoicism that characterize African American women, especially of lower incomes (Lovejoy, 2001). Even during the structured interviews, many of the participants commented that God gets them through hard times and that they can never allow themselves to believe that they have failed in life, and that it is pointless to worry too much about the future because to do so may break one's spirit. It is striking that these comments, however fleeting, are so well represented by the data analysis.

Chapter 6: Discussion and Conclusion

The Mental Health of African American Women

The image of African American women has often been that their strength and resilience in the face of hardship afford them a kind of immunity to mental health problems. However, empirical data suggest that this population is at risk for mental disorders such as depression and anxiety and actually has a higher prevalence of serious mental illnesses such as post traumatic stress disorder and schizophrenia (Brown & Keith, 2003). To a large degree these issues are connected to social problems such as racism, family and community violence, and poverty (Brown et al., 2003; Barbee, 2003). Although African American women are at high risk for psychiatric disorders, it has been found that they do not seek professional treatment for these problems at a rate similar to European American women (Mays, Caldwell, & Jackson, 1996). Many hypotheses have been put forth to explain this discrepancy, including lack of economic resources such as health insurance, a paucity of African American mental health care providers, and history of mistrust of mainstream medicine owing to unethical and exploitive behavior toward African Americans (Mays et al., 1996).

Another plausible explanation may be that, because of their history of social and economic marginality, many African Americans have formulated their own methods for dealing with emotional and psychological distress arising from these difficult social conditions. Church communities and families have often been the most accessible and reliable sources of social

support for African American women. This may be one reason why this population is less likely to seek formal psychiatric treatment for serious problems such as phobias and mood disorders.

This fact was illustrated most clearly just as I was about to conduct an interview with a participant. I was reading the consent form to her, which details the purpose of the study, when she interrupted me to say that black people do not see psychiatrists. I asked her what they do instead. She told me that they do not need to see psychiatrists because they go to church. I mentioned that most people in every ethnic category in the United States go to church but that in some groups, it is common to seek medical care for emotional and mental problems. The participant agreed that most people, regardless of ethnicity, attend church services, but she explained that black people use the church for everything from social and community life to counseling. Indeed many of the participants expressed an interest in seeing a counselor, but emphasized that spirituality is usually missing from secular mental health settings. This was a key reason why some of them preferred to discuss emotional problems with their families or their pastor.

I also found that some participants expressed a reluctance to discuss mental health problems with anyone connected to their church. These participants also said that they would not want their families or friends to know if they were having these kinds of problems. They preferred to handle them alone, with prayer. I asked one participant why she would not want to tell anyone at church if she were experiencing emotional or mental distress. She said:

> I wouldn't want them to think I was really mental because I guess I want them to think that everything's ok all the time. And I wouldn't want them to think that I was burdened down with some major problem that I can't handle or that I wouldn't be able to…I don't know, I think they may distance themselves.

This response exemplifies a phenomenon common to many African Americans that some social scientists have come to call "John Henryism" after the black folk hero John Henry, a steel

driver working on the railroad, who competes against a mechanical hammer and wins, only to die of exhaustion. John Henryism refers to the cultural ideal within African American communities of working hard and tirelessly, usually for the benefit of their families, without regard to one's own comfort or safety (Dressler et al., 2005). Although John Henry is a man, this legend applies equally well to black women who often take on multiple roles as mothers, employees, heads of household, caregivers of aging or ailing relatives, and community leaders. This sort of self-sacrifice, though in some ways satisfying to black women, may exact a brutal toll on their physical and mental well-being. It has been found that African American women are more likely than European American women to continue to work and care for family members while experiencing serious illnesses, including mental illness, of their own (Brown & Cochran, 2003). However, it has also been found that John Henryism has a protective cardiovascular effect for African American women, though not for African American men. The reason for this effect is that traditionally, there have been fewer opportunities for African American men to exercise control in the public domain where they are expected to perform their social roles. In contrast, African American women historically have been able to carry out their expected roles in the private domain, where an "active coping style" is beneficial (Dressler, Bindon, & Neggers, 1998). In this sense, active coping means hard, determined work.

Moreover, the stigma surrounding mental health problems may preclude the possibility of speaking openly about them. To do so would publicly expose one's personal struggles. Stigma may be connected to community values, such as religious belief and participation. While stigma was not associated with religiosity by itself, it was positively correlated with the preference for a religious doctor. Furthermore, stigma is positively correlated with the belief that mental disorders are caused by problems in society. It is possible that the respondents perceived social problems

as profane, or worldly. For this reason, religious piety may be thought to protect communities and individuals from social disorder, and thus, mental disorder. In a sense, mental disorders *and* the secular world may be stigmatized by this group.

Additionally, similar to what Lichtenstein (2008) found in her study of African American adults and HIV/AIDS, stigma may inhibit a depressed person's ability to recognize clearly or acknowledge the symptoms of their illness. Such lack of recognition of depressive symptoms has real health consequences, even beyond psychiatric illness, when they go untreated. For example, even moderate untreated depressive is a serious risk factor for future development of cardiovascular disease (Santangelo et al., 2009; Pikhart et al., 2009; Frasure-Smith & Lesperance, 2005). The fact that one third of the sample was screened as clinically depressed, which is twice the general adult prevalence, ensures that those members of the sample are disproportionately at risk for cardiovascular disease. This is especially concerning because it is already well known that African Americans are at higher risk than European Americans for cardiovascular disease (Bibbins-Domingo et al., 2009).

Of course, many black women deny that they experience any emotional stress at all. I found it to be remarkable that many of the women I interviewed insisted that they had never had any mental distress and that they felt fine all the time. While administering the CES-D scale, many of the participants answered questions that screen for depression with the lowest frequency of "rarely or never". For example, I would ask how many times in the last couple of weeks she felt sad or depressed. Many women would immediately deny ever feeling sad, even though before I began asking the questions I would always say that everyone, including myself, feels "down" sometimes and that I personally feel that it is normal to experience such emotions. It has been suggested that this sort of denial of stress and anxiety is adaptive in the face of constant

struggles with poverty, discrimination, and any social problem that African American women may feel is beyond their control to solve or make less severe (Johnson & Crowley, 1996). It may also be that this population does not identify the emotions associated with the clinical diagnoses of anxiety or depression as indicative of the presence of a mental disorder (Barbee, 2003). Indeed, when I asked participants to give me a list of the different mental or emotional disorders they knew about, many of them told me that they did not know anything about the subject. Perhaps, in this population, these feelings are not thought to be within the domain of medical problems. It has been said that African Americans often prepare their children for life in a world that expresses hostility toward minorities (Nichter, 2000). These children grow up with the knowledge passed on by their parents of what the "real world" is like. In a sense, they are taught to repress negative feelings and not to allow the injustices of living in racist world to trouble them deeply enough to express them openly in the presence of white people. They are taught to rely on other African Americans in their communities for support and self-esteem. This results in a sort of self-reliance that may preclude the treatment-seeking that European Americans commonly engage in when feeling mental distress. If feeling down is not "depression", it is not a reason to see a physician who may not be trusted because he or she does not understand the everyday experience of being black. Instead, it is preferable to deal with such emotions privately; at most, it may be acceptable to lean on the family for support. It is remarkable that this sample exhibited such a high prevalence of depressive symptoms, 33.3 percent. In the general North American population, the probability for women of having depression within a year long period is about 8-10 percent (Murphy, Laird, Monson, Sobol, & Leighton, 2000). Although the moderate inverse correlation ($r = -.311$, $p = .045$) between religiosity and depression appears to suggest that religious activity minimizes depressive symptoms, the high level of depressive

symptoms in this sample indicates that this coping mechanism may not be sufficiently protective against clinical depression.

The socially, economically, and politically marginal position that has historically been occupied by African American women has made them, as a group, vulnerable to experiencing high levels of psychological distress. Variables involved with this process may include poverty, violence, ethnic and gender discrimination, and social role conflict and overload. Traditional sources of social support have been at the community level, located within the family and the church. Mistrust of traditionally white establishments, such as medicine, have deterred African American women from seeking formal psychiatric treatment for mental disturbances. However, it may be that traditional avenues for coping with psychosocial stress are not fully adequate. For this reason, the psychiatric community has demonstrated concern regarding the mental health of this population, but has met significant challenges in reaching out to members who may need professional help. A major challenge to both the medical establishment and the African American community is the stigma that is attached to mental illness. Fear of mental illness, and of others discovering that one is experiencing mental health problems, limits the likelihood that African American women will disclose these conditions to members of their communities. This is one reason why African American women are, in general, reluctant to seek treatment, even though it is possible that many of them might benefit from it.

At present, it is not clear what steps should be taken to ameliorate this problem. From my research, however, I have tentatively concluded that social norms within this community may be heading in a new direction. Many women indicated during the structured interviews that they would see a counselor or physician for these problems. Yet during the open-ended interviews, they often expressed an interest in the incorporation of elements of spirituality in therapy. My

impression is that this population would benefit from a new model of therapy – one that combines mainstream biomedical, pharmacological and psychotherapeutic methods with elements of faith and spirituality. The underlying biomedical causes of mental distress need to be addressed, but this should be done within the religious and spiritual frameworks in which many African American women conceptualize emotional, mental, and physical health. African American female patients may respond more completely to this kind of culturally sensitive approach to treatment.

The results of the analysis of this research depict a complex picture of the sample's conceptualization of mental health. The research hypothesis was not supported. There was no significant association between religious orientation and the likelihood of seeking formal medical treatment for mental health problems. The participants gave little indication that they explicitly connected their religious beliefs with their opinions about mental health care. Both the high religiosity and low religiosity groups were equally likely to say that they would see a physician or counselor and that they would take prescription medication if they were experiencing serious mental distress.

However, there were some findings that confirmed some of the ideas driving the hypothesis. There was a significant association between religiosity and the belief that prayer can cure mental illness and a moderately inverse correlation between religiosity and depression. There were significant inverse associations between income and the influence of religion on health care decisions, the mistrust of physicians, and the presence of depressive symptoms. Those with depressive symptoms were marginally more likely to believe that doctors would not want to help them because they are African American.

Moreover, during open-ended interviews, respondents frequently attested to the power of prayer. For these women, prayer was a healing force in their lives, one which could alleviate dysphoric feelings such as anxiety, depression, and anger. Some respondents relayed traumatic stories in which prayer had been their most trusted method of coping through extreme personal tragedy. However, they also expressed caution regarding the disclosure of high levels of psychological distress to members of their communities such as fellow churchgoers, family members, and friends. These women emphasized their need to be strong in the face of adversity, and to maintain the appearance of invincibility to personal pain and stress.

It is my interpretation that the participants in this sample are, for the most part, very strong women who are willing to sacrifice their own comfort to provide financial and emotional security for their families and communities. In doing so, they may deny their own problems to their loved ones and often to themselves. As a result, they may prefer to handle stress in a private manner, by relying on their personal relationship with God. The ritual of prayer is engaged in frequently, and often imparts an effect of relief and calm when faced with extreme stress and dissatisfaction. These women take pride in their independence and ability to weather difficult circumstances. Although they are not opposed in principle to seeking professional help for extreme mental health problems, they generally prefer to take care of themselves. Most importantly, they do not wish to be perceived by others as a burden. Rather, they prefer to place others' needs before their own.

However, although many of these women take pride in their independence and experience a certain amount of satisfaction in sacrificing their own needs for those of their loved ones, they often report feeling overwhelmed by their responsibilities. They say that at times they feel that they experience more stress than they can handle by themselves. A number of

participants experienced significant levels of depressive symptoms. It is my contention that conventional methods of coping with stress may not be fully adequate for this population. It is possible that they could benefit from mental health treatment that is specially tailored to fit their unique emotional, cultural, and spiritual needs. The major challenge in this arena is to accomplish this goal in the face of persistent mistrust of the medical system.

Limitations

There are a number of limitations to this research. The research design did not utilize a random sample. Instead, convenience sampling was used to find research participants. The effect of using a convenience sample rather than a random sample is that the data collected from this sample may not be representative of the actual population of local African American women. For example, approximately two thirds of the sample was recruited from manufacturing companies. All but two of the participants recruited from these locations were hourly production workers. For this reason, it is possible that lower income women were oversampled in this research project. Additionally, the sample size is small.

Another limitation is that, although cognitive anthropological theory informed the theoretical structure of the research, cognitive methods were not used. I had initially planned to use cultural consensus analysis but ultimately this was not possible because of the difficulty I had in recruiting research participants. I was able to conduct a free-listing activity with the respondents who were interviewed, but I was not able to find enough participants in order to complete the pile-sorting activity that is necessary for consensus analysis.

Additionally, because so many of the interviews were conducted on site at a place of employment, the participants were under a certain amount of pressure to complete them fairly

quickly so they could go back to work on the production line. Additionally, there were participants who said that they did not know how to answer some of the questions. Even after giving them ample time to think about their responses, and assuring them that there is no "right" answer, some of the participants still did not know how to respond. Consequently, there are missing responses to many of the questions. This may have decreased the strength and reliability of the data.

Finally, the reliability of some of the data may be in question for a couple of reasons. First of all, it is well known that people often over-report socially desirable behavior, such as religious participation (Bernard, 2006). Since a number of the questions in the interview schedule concern religious participation, and since religious orientation is a central part of the investigation, the potential overstating of religious participation may throw the analysis and conclusions into question. Related to this is the fact that it was next to impossible for me to find participants who were not very religious. A relative lack of resources, including time, prevented me from thoroughly searching for non-religious participants. Therefore, instead of interviewing participants who self-identified as not religious, I resorted to dichotomizing the sample into high and low religiosity based on the answers to the questions in the interview schedule.

Second, it is possible that the data may be affected by the dynamics of the interview process. All of the participants were African American and I conducted all of the interviews. Because I do not share the same ethnicity as the participants, it is possible that some may not have felt comfortable answering some of the questions in a completely truthful manner. I do not mean to imply that it is likely that participants were consciously deceptive, but rather that it is possible that the research may have yielded more candid responses if the participants had been interviewed by a person of the same ethnicity. Other cultural differences between the researcher

and informants that may have been of consequence included geographic origins and level of education.

Thus, further research is needed in the area of religion, mental health, and African American women. A more nuanced analysis may result from more precise or refined research methods such as random sampling, a larger sample, and the utilization of interviewers of the same ethnicity as the participants. However, despite these limitations, I was able to gather enough data to confirm some of the ideas that influenced the formulation of my hypothesis. The results of this project also validate the importance of using anthropological theory and methods to investigate this important public health problem.

Conclusion

This study demonstrates the complex nature of the relationships between mental health, religion, culture, and social roles that African American women experience in the Southern United States. The stereotype of the invincible, independent African American female has given way to a more realistic picture of women who are often overburdened, anxious, depressed, and reluctant to seek help. These are women who are doing the best they can with the resources they have at hand. Unfortunately, the resources are often not enough. And although many of the women said they would use medical services if they needed them, and one third of the sample has significant depressive symptoms, it seems that they would be unlikely to do so unless their symptoms were much more severe than they have to be to warrant psychiatric attention. From the data I have collected and analyzed in this project, it seems likely that the women in this sample have a cultural conception about depression that differs from that of the mainstream medical establishment and possibly from that of the “mainstream”, middle class, white lay

population. The set of beliefs and experiences about the arduous nature of life for black women may preclude members of this group from believing that moderate emotional distress and physical exhaustion are medical conditions that may benefit from professional attention. Instead, for these women, "depression" means utter incapacitation. Frequently, these women referred to someone they knew having a "nervous breakdown". When I asked what had happened, they described symptoms characteristic of a major depressive episode. To say that someone has had a "breakdown" is to declare that he or she is dysfunctional. This may explain why so many of the respondents said they would seek treatment for mental disorder, even though the national data demonstrate that the population they may represent is significantly less likely to do so. The definition of mental disorder for southern African American women is so extreme that they believe that they have not experienced it, but would seek help if it occurred. This is remarkable considering that the sample's level of depression, 33.3 percent, was more than twice that of the general American population.

Additionally, although the medical community is aware that this is an underserved population and has attempted outreach efforts, there is much historical baggage remaining from when mainstream medicine did not have such sincere and noble motives. It is going to take more effort to reach African American women who are in serious need of mental health care. Alliances between religious and community groups and the medical community could prove fruitful in this endeavor. Also, there is a significant need for more African American female mental health care providers. The presence of a psychiatrist, therapist, or counselor who is also a black woman may put members of this population at ease, because they will know that such a health care provider has intimate knowledge of the unique difficulties that these kinds of patients face day to day. As with many other public health efforts, a certain amount of effort to change the status quo must

come from within the population in need. This means having honest, compassionate dialogue within the African American community about mental illness. By joining forces with respected members of these communities, health care providers and social science researchers may finally be able to gain the trust of a population whose relief from emotional and mental distress has been long overdue.

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Appendix A: Interview Schedule

Case ID _____ Date _____

Mental Health Treatment-Seeking Behaviors of Ethnic Minorities – Interview schedule

For this interview, I am going to ask you some questions about your thoughts, feelings, and opinions on several topics, including religion and mental health. There are no right or wrong answers to any of the questions. Just speak from your own experience and speak from your heart. You may find some of the questions to be personal. If for any reason you do not want to answer a question, you do not have to. Take your time. There is no rush. If you are unclear about a question, please feel free to ask me about it. If you would like to take a break from the interview, just let me know. If at any time during the interview you feel that you want to quit, just tell me. Nothing bad will happen if you decide to quit the interview.

The interview has two parts. The first part has several questions which may be answered with short answers of a few words, for example "agree/disagree". The second part of the interview has some open-ended questions in which you can give longer answers. The second part is optional. At the end of the first part, I will ask you if you would like to move on to the second part. Again, if at any time you are unclear about something, please feel free to ask me about it.

Are there any questions you would like to ask up front?

Are you ready to get started?

I – <u>Religious and spiritual orientation</u>

These questions are about your thoughts and feelings on religion. For each question, please say whether you agree or disagree with the statement.

1. I practice my religion about as often as most other people I know.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

2. Spirituality affects how happy a person can be.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

3. I have had powerful spiritual experiences in my life.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

4. I wish I had a closer connection with God.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

5. I do not believe in divine intervention.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

6. I do not feel like I have a close relationship with others at my church.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

7. It is not very important to have my church's approval of my behavior and personal choices.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

These questions are about how often you take part in religious activities. Which answer best fits you?

8. How often do you go to church? (0 – more than once a week, 1 – once a week, 2 – twice a month, 3 – once a month, 4 – a few times a year, 5 – never or almost never)
9. How often do you pray or meditate? (1 – more than once a day, 2 – once a day, 3 – once a week, 4 – once in a while)
10. How often do you read the Bible or other religious books? (1 – more than once a day, 2 – once a day, 3 – once a week, 4 – once in a while, 5 – never or almost never)

II – <u>Demographics and social support</u>

These are some general questions about you and your household and your social relationships.

1. What is your date of birth? _____
2. What is your marital status? (never married, married/partnered, widowed, divorced/separated)
3. How many children do you have? _____
4. Please tell me who all the people are who live in your household, by first name only.
5. What is your relationship to each person?

First name	Relationship

6. What is your household yearly income? _____
7. Who do you depend on the most to help you with everyday situations?

   _____

   _____

   (family, community, professionals)
8. What kinds of problems do you often feel you need extra help with?

   _____

   _____

   _____
9. When you need help with (particular problem), how often do other people help you? (always, usually, sometimes, rarely, never)
10. Have you ever felt like your problems were causing more stress than you could handle by yourself? (yes/no)

III – Health care and well-being

These questions are about your thoughts and feelings about mental health care and well-being.

For each question, please say whether you agree or disagree with the statement.

1. I would tell my friends if I had mental health problems.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

2. I do not trust doctors and other health care professionals.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

3. I would tell my employer if I had mental health problems.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

4. I would see a counselor if I had mental health problems.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

5. I think doctors and therapists really want to help their black patients.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

6. I would talk to the doctor about mental health problems.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

7. My health care decisions are not influenced by my religious beliefs.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

8. I would take medication for mental health problems

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

9. Spirituality is an important part of mental health treatment.

   Agree: (a little) (a lot)
   Disagree: (a little) (a lot)

10. I would rather talk to a religious doctor than a non-religious doctor about mental health problems.

    Agree: (a little) (a lot)
    Disagree: (a little) (a lot)

11. I'm not sure why this happens, but sometimes I have mysterious aches and pains.

    Agree: (a little) (a lot)
    Disagree: (a little) (a lot)

12. I would rather talk to a religious counselor than a non-religious counselor about mental health problems.

    Agree: (a little) (a lot)
    Disagree: (a little) (a lot)

13. I would rather go to a health care professional than another person for help with a physical illness

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

14. I depend on the people I know from church to feel good mentally.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

15. I would rather go to a pastor than another person for help with a physical illness.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

16. Sometimes I feel really tired for no clear reason.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

17. I would rather go to a health care professional than another person for help with a mental illness.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

18. I do not feel that white doctors and counselors take their black patients' complaints seriously.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

19. I would rather go to a pastor than another person for help with a mental illness.

    Agree: (a little) (a lot)
    Disagree: (a little) (a lot)

These are some questions about how you think about health care. Please give me the answer that best describes you.

20. In order of first to last, which of these things do you do to feel better when you don't feel well? (take care of self at home, go to primary doctor, go to emergency room, go to alternative healer [such as a naturopath, herbalist, massage therapist, etc.], visit pastor/church, other___)
21. How often do you visit the doctor? (once a week, more than once a month, once a month, twice a year, once a year, less than once a year)
22. In order of first to last, who would you talk to about mental health problems? (1 – doctor, 2 – friend, 3 – family member, 4 – pastor)

III – Opinions on mental health

These questions are about your thoughts and feelings about mental health problems. For each question, please say whether you agree or disagree with the statement. Then say whether you agree (or disagree) a *little* or a *lot*.

1. Mental problems are caused by family problems.

    Agree: (a little) (a lot)
    Disagree: (a little) (a lot)

2. Mentally ill people are dangerous.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

3. People can become addicted to medications taken for mental health problems.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

4. Mental problems are caused by bad life experiences.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

5. Mental illnesses are natural diseases similar to medical problems like, for example, diabetes or arthritis.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

6. Mental illnesses are caused by making bad choices.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

7. Mental illnesses are causes by stress.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

8. People who lead sinful lives often have mental problems.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

9. Mental illnesses are caused by society.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

10. It is better to stay away from mentally ill people.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

11. Mental illnesses are caused by immoral behavior.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

12. Mentally ill people need the support of others to get better.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

13. Mentally ill people can never get better.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

14. God can cure mentally ill people directly.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

15. Mentally ill people can get better if they talk to a counselor.

Agree: (a little) (a lot)

Disagree: (a little) (a lot)

16. Mental illnesses can be treated with medications.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

17. Mentally ill people can be cured with prayer.

Agree: (a little) (a lot)
Disagree: (a little) (a lot)

IV. - CES-D scale

These are some questions about your thoughts and feelings about your own health. This is a list of some of the ways you may have felt or acted. Please say how often you have felt this way during the past week. You may have felt this way [will give laminated cards]: (a – rarely or none of the time {less than 1 day}, b – Some or a little of the time {1-2 days}, c – occasionally or a moderate amount of the time {3-4 days}, d – all of the time {5-7} days).

1. I was bothered by things that usually don't bother me. (a, b, c, d)
2. I did not feel like eating; my appetite was poor. (a, b, c, d)
3. I felt like I could not shake off the blues even with the help of my family. (a, b, c, d)
4. I felt that I was just as good as other people. (a, b, c, d)
5. I had trouble keeping my mind on what I was doing. (a, b, c, d)
6. I felt depressed. (a, b, c, d)
7. I felt everything I did was an effort. (a, b, c, d)
8. I felt hopeful about the future. (a, b, c, d)
9. I thought my life had been a failure. (a, b, c, d)

10. I felt fearful. (a, b, c, d)

11. My sleep was restless. (a, b, c, d)

12. I was happy. (a, b, c, d)

13. I talked less than usual. (a, b, c, d)

14. I felt lonely. (a, b, c, d)

15. People were unfriendly. (a, b, c, d)

16. I enjoyed life. (a, b, c, d)

17. I had crying spells. (a, b, c, d)

18. I felt sad. (a, b, c, d)

19. I felt that people do not like me. (a, b, c, d)

20. I could not "get going". (a, b, c, d)

Would you like to do the second part of the interview?

(If no): Thanks very much for taking the time to be interviewed. I appreciate your help.

(If yes): Would you like to take a short break first?

V – <u>General questions (will provide extra paper for each question)</u>

The questions in the second part of the interview may take longer to answer than the questions in the first part, depending on how much you would like to talk about. These are some open-ended questions about your experiences, thoughts, and feelings on religion, spirituality, mental health, health care, and well being. Feel free to answer them any way you like. You may prefer to tell a story, or to talk about the experience of a friend or family member. Any of these ways of talking about the questions is fine. If you are uncomfortable with a question, you don't need to answer it.

1. What are the things you do to feel happy, healthy and at peace with yourself and others?
2. What is your church like? What sort of people do you go to church with?
3. What does the word “spirituality” mean to you?
4. Is there a difference between being a “spiritual” person and being a “religious” person? If there is, please tell me what you think makes them different from each other?
5. How do you feel that God works in your everyday life?
6. Could you please tell me about an experience you had that was spiritual?
7. In what ways do you think doctors and pastors are different as people to go to for help in times of trouble?
8. In what ways do you think doctors and pastors are similar as healers?
9. Can you recall a positive experience you had with a health care professional? What did that person do to make you feel better?
10. Can you remember a negative experience you had with a health care professional? What happened that made you uncomfortable or upset?
11. Why do you think you experience stress or sadness in your life?
12. Try to think back to a time when you were so stressed with everyday life that you weren’t sure how to cope. How did you handle the stress?
13. Have you have known someone that had a mental health problem? (If yes) Please tell me a little about this person.
14. What do you think causes people to become mentally ill?
15. Which people would you feel uncomfortable talking to about mental or emotional problems?

VI – Free-listing (will provide extra paper for each question)

Please name everything you can think of relating to each question. There are no right or wrong answers. Please just speak from your own knowledge and experience.

1. What are the mental illnesses you know about?
2. What are the causes of common mental illnesses you know about?
3. What are the treatments you know about for common mental illnesses?

Appendix B: IRB Approval

Office for Research

Office of the Chair,
Institutional Review Board for the
Protection of Human Subjects

THE UNIVERSITY OF
ALABAMA
RESEARCH

July 11, 2008

Kathryn Oths, Ph.D.
Department of Anthropology
College of Arts & Sciences

Re: IRB # 08-OR-154 "Mental Health Treatment-Seeking Behaviors of Ethnic Minorities"

Dear Dr. Oths:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your protocol has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Should you need to submit any further correspondence regarding this proposal, please include the assigned IRB application number. Please use reproductions of the IRB approved informed consent form to obtain consent from your participants.

Good luck with your research.

Sincerely,

[redacted]

Carpantato T. Myles, MSM, CIM
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