RISKS AND BARRIERS: AFRICAN AMERICANS' RELUCTANCE TO SEEKING MENTAL HEALTH TREATMENT

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ABSTRACT

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Minimal research exists in reference to African American families and their willingness to attend therapy. The focus of this research study was to determine the reasons African Americans are skeptical to participate in therapy. Some research shows that the number of African Americans that attend therapy continues to rise; however, there continues to be factors that keep African Americans from using therapy as a means to solve problems. A large number of studies provide data explaining potential factors that hinder or distort the views of African American mindsets about why therapy should be utilized in their community.

Through a critical race theory lens, the proposed study examined how access and exposure affect African Americans behaviors to seeking mental health treatment. Secondly, the study analyzed whether mental health barriers and religiosity predicted whether African Americans sought mental health treatment. Specifically, this study utilized the secondary data from the Collaborative Psychiatric Epidemiology Surveys (CPES), 2001-2003 (534 African American respondents) to consider how insurance access and gatekeeper exposure are associated with mental health treatment. Additionally, whether mental health barriers and religiosity predicted African American behaviors to seeking mental health treatment was also examined.

The responses of African American participants who had either access or exposure towards mental health were addressed. The responses of predicting whether religiosity and mental health barriers affecting African Americans from seeking mental health treatment was also addressed. Then, the two research hypotheses were addressed. With respect to the first research hypothesis, "African Americans who have access and exposure will increase their behaviors towards utilizing mental health treatment," the results of the statistical analysis did support this hypothesis. Regarding the second research hypothesis, "Mental health barriers and religiosity will predict whether African Americans seek mental health treatment," results were not supportive of this hypothesis.

The results from the research showed that African Americans who have access and exposure to mental health treatment are more likely to utilize treatment than those who do not have the same access. However, the research results did not support the hypothesis that mental health barriers and religiosity predicts whether African Americans choose to seek out mental health treatment.

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CHAPTER I

INTRODUCTION

"Despite progress made over the years, racism continues to have an impact on the mental health of Blacks/African Americans. Negative stereotypes and attitudes of rejection have decreased, but continue to occur with measurable, adverse consequences. Historical and contemporary instances of negative treatment have led to a mistrust of authorities, many of whom are not seen as having the best interests of Black/African Americans in mind." (Ellis, 2019, p. 9)

Research shows African Americans are reluctant to seek therapeutic help, and this reluctance leads them to be discouraged and unable to seek out counseling services. There appears to be reluctance when African Americans are influenced culturally or have felt stigmatized in the mental health field. When African American individuals take steps towards seeking services, they are less likely than Caucasians to stay committed (Campbell & Mowbray, 2016). According to Awosan, Sandberg, and Hall (2011), African Americans do not use therapeutic services and appear inconsistent with whether to continue services when they do seek therapy. Instead, they are likely to use various coping strategies such as religious practices, spirituality, their family members, and community resources in problematic situations before considering mental health services (Awosan et al., 2011).

Karatzias, Jowett, Begley, and Deas (2016) implied that ridicule in the African American community stems from historical adversity, slavery, race-based exclusion from educational, health, social, and economic resources. These are attributes from

socioeconomic inequalities experienced by African Americans. African Americans' mental health status are directly linked to stigma and socioeconomic status (Karatzias et al., 2016). Skepticism about mental health treatment and use in African Americans is a reason for the minimal actions to seeking services. Literature reveals that perceived discrimination, skepticism, stigma, and culture are a stronghold to the hesitance to treatment seeking behaviors (Gaston, Earl, Nisanci, & Glomb, 2016). African American attitudes also reflect that there is a lack of acknowledgement that mental health problems are also medical problems. Historical oppression and racist experiences are contributors to the lack of trust in white professionals. Psychological functioning is compromised due to these clinically significant impairments. However, there are some African Americans who display resiliency, but there are others who are not as resilient; thus, needing mental health treatment (Karatzias et al., 2016). A recent study that focused on minorities in mental health identified that barriers to treatment engagement matched historical barriers to include ambivalence about treatment efficacy and trouble finding proper and financially affordable treatment (Moore, Lopez, Camacho, & Munson, 2020). Several relative barriers exist that prevent African Americans from seeking mental health services, including cultural mistrust, stigma, multicultural competence, lack of awareness and knowledge, and cultural beliefs.

Currently, there is research to describe elements that discourage the African American community from seeking therapy, and specifically, why some African Americans do not seek mental health services at all (Hall & Sandberg, 2011). These elements include unequal treatment, minimal access, and distrust for mental health

professionals. Mental health in African American communities has not been thoroughly researched because many African Americans do not want to be evaluated.

According to Thompson, Bazile, and Akbar (2004), African Americans are less likely to seek mental health services and continue participation in therapy sessions. Due to the lasting impact of slavery, African Americans continue to face economic and social disadvantages due to discrimination, racism, and political inequalities (Thompson et al., 2004). There are approximately 40 million African Americans and it is vital to determine how to enhance therapeutic treatment within the African American culture. There is an understanding that there is a general stigma related to any individual with mental illness; however, African Americans feel there is increased stigma including both race and mental health status. African Americans have felt stigmatized since slavery, and their concern is that adding additional stigmatizing identity could have negative effects for minorities (Campbell & Mowbray, 2016).

Having knowledge regarding African American history and culture helps to understand the diverse perspectives that are related to mental health reluctance. One method to enhancing therapeutic treatment would be for the therapist to address potential fears of an African American client who enters their office (Thompson et al., 2004). Historically, African Americans were conditioned to have therapeutic distrust through explicit and subconscious messages imparted by their families, communities, music, religious rituals, values, perceptions, and experiences that derived from their unequal treatment in America (Hall & Sandberg, 2011). It has been recommended to therapists to have an honest conversation with clients about how race affects them, but not to require

clients to sum up their complete racial experience, as it is more complicated than that. The African American community has been shown to be more inconsistent than Caucasians when seeking therapy. The mental health field focuses their attention on how, when, or whether to address these barriers and how it will affect the attitudes of African Americans (Thompson et al., 2004).

African Americans tend to rely on family, religious, and social communities for emotional support rather than turning to health care professionals, even if there is a need for mental health services (Carr & West, 2013). One belief is that the appropriate way to handle family concerns is within the family. According to Carr and West, it is frowned upon in the African American community to discuss private information with a person who has not earned their trust. In a study conducted by Carr and West (2013), African American men felt that therapy could weaken their pride as they are seen as the protector and head of the household. Likewise, African American women felt that they must be the caregiver and source of strength in the family. Due to the reliance of religion in the form of coping with mental health, churches are now attempting to bridge the gap by having staff members receive mental health training. This gives the church members an opportunity to skill build, while staff serves as advocates and mental health educators. Connecting the church and mental health can alleviate identified stigma and encourage participation from members (Scribner et al., 2020).

Another element that keeps African Americans from therapy is a lack of awareness about the mental health field. According to Kelly, Maynigo, Wesley, and Durham (2013), therapy is viewed as an amenity instead of a necessity. Lack of

awareness in the field of mental health include understanding mental health symptoms as well as deciding the appropriate times to attend. Some have trouble deciding what conditions require therapy or when a circumstance has reached a stage that is necessary to receive help. This lack of knowledge also means that many do not know the signs of mental illness.

Lack of knowledge contributes to the notion that mental disorders receive less focus and attention than ailments of physical health (Neely-Fairbanks, Rojas-Guyler, Nabors, & Banjo, 2018). The stigma of mental health in the African American community increases reluctance to discuss mental health conditions. African Americans who lack knowledge share a perspective that participation in mental health is a sign of weakness. Community activists, mental health professionals, and history have contributed to the minimal knowledge that is associated with African Americans' distrust in mental health care providers and their lack of access. Statistics report that there are differences in knowledge obtained by race or ethnicity. Lack of access is not only viewed from the lens of location but through the use of insurance. There are differences in mental health access among races. In spite of the changes economically, the benefit of African Americans' receiving insurance through their jobs is lower than that of Caucasians. Approximately 73% of Caucasians have job related insurance compared to 53% of African Americans. (Brown, Ojeda, Wyn, & Levan, 2000). The mental health field can minimize health inequalities by providing culturally and linguistic focused care. Lack of insurance is viewed as a barrier to seeking mental health treatment. In the US, having health insurance is most likely to occur through employment benefits. African Americans in comparison

to Caucasian individuals, are often employed in jobs that do not offer health insurance coverage (Murry, Heflinger, Suiter, & Brody, 2011).

African Americans who have more positive attitudes regarding mental health reported that they are more likely to express feelings of embarrassment to their close friends or family who were aware that they utilize services (Neely-Fairbanks et al., 2018). Suppression in the minority community includes themes related to hardships, depression, and significant life changes (Neely-Fairbanks et al., 2018).

Religious beliefs are a very important aspect of the African American community and also a potential barrier to seeking therapy. There are some individuals who believe that God will save them of all mental illnesses, and if this is not a belief then their faith is compromised (Kelly et al., 2013). In times of distress, many African Americans turn towards their religious leaders, pastors, reverends, bishops, or deacons. There is an affirmative view to turn towards these people because to the public, it reaffirms the belief that God can solve all problems (Kelly et al., 2013).

Contrary to the widely discussed viewpoint of religion, racial inequalities faced by minorities are considered a social justice and a public health concern. The concerns are relative to untreated mental health. Interventions in the church can work to minimize mental health disparities while also increasing mental health outcomes for African Americans. Questions about whether churches are equipped to address the mental health needs of their members have been a recent topic in literature. Although elements such as education, health resources, and economic support are provided to members in the church, there has been an upgrade to include programs that encourage mental health

(Hays, 2015). The upgrade serves as a new way of thinking that combines both religion and mental health.

Programs that are implemented in the church include the Church Based Health Promotion (CBHP) program. CBHP interventions focus on addressing mental health in the African American church through Helping Alleviate Valley Experiences Now (HAVEN; Hays, 2015). The focus of HAVEN is suicide prevention for African Americans who identify and show signs of being at risk for suicide to a mental health provider. In conjunction with the program in the church, community education is also used to spread awareness. The goal of these programs is to build alliances between the church and mental health agencies (Hays, 2015).

African Americans lack trust when seeking mental health treatment. Minorities report that more attention should be placed on help-seeking behaviors, increasing access, and cultural competency. Additional barriers include denial of symptoms, feeling loss of control regarding their mental health, and differing beliefs about the origin of their mental health issues (Avent, Cashwell, & Brown-Jeffy, 2015). Negative stereotypes connected to mental health pose as a barrier in the African American community. Stereotypes include African Americans judging that white professionals are all racist, as well as how mental health treatment is non-essential. The stereotypical perspectives linger including being weak, or that mental health treatment is a luxury (Chandler, 2019). Stereotypes, finances, insurance, and cultural differences all fit into the equation explaining African American reluctance.

Stigma and the fear of being mislabeled or mistreated are important aspects of not wanting to be treated differently due to a specific diagnosis (Breland-Noble, Bell, & Nicholas, 2006). Culturally, there has been a mindset that seeking help for one's mental health translates to being viewed as broken or weak (Thompson et al., 2004). Ward, Wiltshire, Detry, and Brown (2014) analyzed the perspective of African American men and women towards mental illness. The results indicated that African Americans were more likely to believe that mental illness could be solved on its own. There was another conclusion that older African Americans viewed mental health as a weakness.

There is a cultural perspective that one seeks assistance within the family system or through a higher power (Thompson et al., 2004). However, there is research describing the need to collaborate with religious institutions in order to shift the cultural perspective. With this knowledge stems the development of culturally competent clinicians. Literature has been written on the benefits of being culturally competent (Taylor, Chatters, Levin, & Lincoln, 2000). Clinicians who are culturally competent can show attributes of empathy, normalize the historical perspective, and elaborate about reasons why minorities should seek and continue therapy (Taylor et al., 2000). Literature on African Americans coping with mental health primarily with religion is limited. Studies have reported that African Americans utilize religion to cope with mental illness as well as indicating willingness to seek treatment. In comparison to 66.7% of Caucasian Americans, .0.4% of African Americans report using religion as a coping resource (Ward et al., 2014).

This study sought to contribute to our understanding of how access and exposure, as well as religiosity, work together to impact African Americans' behaviors to seek

mental health treatment. Specifically, through a critical race theory lens, the current study considered racism's impact on mental health at the macro and micro levels while considering power, privilege, and social location.

The Current Study

The current study examined the impact of access and exposure on African Americans' behaviors to seek mental health services. Additionally, the study analyzed whether mental health barriers and religiosity predict whether African Americans seek mental health treatment. The following research questions were tested:

Research Questions:

(1) How does access and exposure to treatment affect African Americans' behaviors towards utilizing mental health treatment?

(2) Do mental health barriers and religiosity predict whether African Americans seek mental health treatment?

Hypotheses:

1) (a) African Americans who have access will increase their behaviors towards utilizing mental health treatment; and (b) African Americans who have exposure will increase their behaviors towards utilizing mental health treatment.

2) Mental health barriers and religiosity will predict whether African Americans increase their mental health treatment.

Results of the current study contributed to the existing literature concerning the stigma and reluctance African Americans have towards the field of mental health. First, the results provided further support for existing literature exploring the relationship

between access and exposure in the African American community. Additionally, this study assisted the field of mental health by understanding how mental health professionals can bridge the gap between race and mental health services.

These findings added to existing knowledge and helped researchers, educators, and clinicians to understand African Americans and how they are impacted by stigma related variables towards mental health. The insight from this study is important for professionals in the field of mental health to understand how to work with people of color while knowing risk factors to build reluctance. Furthermore, this study analyzed whether mental health barriers and religiosity predicted whether African Americans seek mental health treatment.

The findings were beneficial in understanding how to connect the dots between African American culture and mental health culture. It is imperative that the field of mental health expand its cultural competency to reach minority audiences in order to strengthen their participation and potentially reverse negative mindsets. The objective is to "reach one, teach one." The research produced some knowledge on how to reach the African American community and identified how to include this audience. The findings will assist clinicians and the field of mental health in changing racial differences, statistics, and the possibility of stigma minimization.

CHAPTER II

LITERATURE REVIEW

Seeking mental health in the African American community is a continued taboo. Societal factors influence vulnerabilities in African Americans who report that the mental healthcare system is difficult to navigate than the already complicated healthcare system (Haynes et al., 2017). African Americans share a similar perspective that mental health professionals are collecting information about minorities in order to reveal vulnerable content that could put them at risk for further ridicule (Campbell & Long, 2014). People of color, although at a higher mental health risk, are reluctant to seek help for several reasons. Reasons can be attributed to feelings of determination and resilience engrained since birth, especially as it relates to surviving oppression and slavery (McDowell & Jeris, 2004).

Full comprehension of the level of mistrust that has created a negative climate towards mental health is one of the critical components to understanding the African American mindset (Rollock & Gordon, 2000). Distrust comes from continued societal discrimination, the lack of action to increase access, and an attempt to understand what and how therapy is beneficial or worth the effort (Williams-Washington & Mills, 2018). Another perspective is that mental health is not at the top of the priority list because of cost, inconvenience, and contributing to struggles economically (Campbell & Long, 2014). In comparison to Caucasians, African Americans are known to have more mental health struggles but are not actively seeking services for their presenting problems.

Racism, distrust, access, and the faces of mental health contribute to the barriers and hesitation towards the mental health field (Masko, 2005). African Americans are working to minimize the historical stigma by reporting reasons for reluctance, yet wonder what efforts are being made by the field of mental health to address concerns of minorities (Williams-Washington & Mills, 2018).

Defining race in the United States consists of many facets. Race is composed of immigration history, oppression, and European colonization that has strengthened racism. For the purpose of this research study, race is considered a group of people sharing the same culture, history, language, etc. (Rollock & Gordon, 2000). When assessing racism, factors include prejudice, discrimination, or antagonism directed against a person or people on the basis of their membership in a particular racial or ethnic group, typically one that is a minority or marginalized. Racism is considered a group of people who are labeled superior to all other groups (Rollock & Gordon, 2000). Racism implies distress in human relationships that causes negative outcomes for the victims involved. Racism influences habitual behavior that can prevent access to essential resources promoting knowledge and mental health treatment. History provides examples through slavery, the Tuskegee Syphilis Experiment, Jim Crow, etc. that Caucasians used their superiority to discriminate in order to look down upon or harm other racial groups (Delgado & Stefancic, 2001).

Culture that is molded into a common belief system and shared practices often associate with race. African Americans and other people of color have not adopted or been awarded the same privileges as their Caucasian counterparts (Brown, 2008). This

creates a “divide and conquer” society with African Americans submitting to the white cultural norm. The development and focus of critical race theory (CRT) can assist in understanding how the United States culture influences minority decision making.

Critical Race Theory

CRT was developed by activists to assess the ongoing relationships with power, race, and racism combined (Delgado & Stefancic, 2001). Beginning in 1970, lawyers, scholars, and activists collectively gained insight about the regression that was occurring in society after there was great progress made during the civil rights era (Price, 2010). What they found was that racism was continuing in both subtle and overt forms and that there was a need for a theory to serve as a foundation to address racist acts (Delgado & Stefancic, 2001). CRT urges the uncovering of the widespread nature of racism in the field of mental health. The theory aims to illustrate the hardships that arise when racial and other categories such as: gender, age, sex, financial, and social privilege are created as equal groups. CRT masks the diversity, history, and multiple identities of the African American community (Mills & Unsworth, 2018).

Derrick Bell, Alan Freeman, and Richard Delgado joined to formulate the foundation of critical race theory. Both critical legal studies (CLS) and radical feminism were influential to the development of CRT (Delgado & Stefancic, 2001). Critical legal studies is known for addressing liberalism and bringing awareness that the law was not neutral and equal rights should be a top priority. Both African Americans and CLS were treated as insignificant. The feelings of agitation, marginalization, and distress that was brought to society’s awareness led to the development of CRT.

Solid activists in African American history shared the same willingness to develop a theory such as CRT. These individuals included Sojourner Truth, Frederick Douglass, W.E.B. Du Bois, Martin Luther King, and more (Delgado & Stefancic, 2001). While there were a number of leaders and influences that developed CRT, Derrick Bell is named as the founding father of CRT. Bell was a law professor at NYU and continues to educate society today. Alan Freeman is also known for his input to CRT and continues to develop research on racism in the United States.

Beliefs of Critical Race Theory

Literature on CRT includes the notion that racism is ordinary, not aberrational. This is considered normal science, also defined as the societal norm, a common experience for minorities in the world (Delgado & Stefancic, 2001). Labeling racism as ordinary also condones behavior of the majority, thereby making it difficult to pinpoint racism in general (Jackson, 2014). Thinking about race organized around making efforts to not see or recognize racial differences is referred to as colorblindness (Cunningham & Scarlato, 2018). Colorblindness is a way to minimize racism and make it more acceptable in society. CRT aims to understand the norms and production of a racial power structure (Cunningham & Scarlato, 2018). Reducing mental health disparities is the key to addressing colorblindness. There is emphasis on individualism so that everyone has an opportunity to receive adequate treatment services. Research indicates that mental health care workers are reluctant to acknowledge that they could be a part of the problem. The promotion of certain actions in the mental health field, colorblindness may reduce barriers to seeking mental health (Cunningham & Scarlato, 2018).

Interest convergence is also considered as a basic tenet of the theory. This concept purports that when we bring awareness to racism and call for change, this acts more in favor for the white man's interest than the African American community (Masko, 2005). The purpose of interest convergence is for the advancement for the African American community; however, the advancement is considered in terms of personal costs and gains. When the majority advocates for social, political, or economic change, the results reflect their self-interest that is non-inclusive. Bell (2009) pointed out that minority's progress in society when whites find benefit as well. The principle of interest convergence is subject to time and place where the interests coincide to both African American and Caucasian individuals. Interest convergence displays that if there is a shift where Caucasians are not favored, this could alter the circumstances (Morrison, 2018). Social construction argues that race and racism are two attributes created solely by society as a convenience. These attributes are considered irrelevant objectively, biologically, and genetically. Race was created for the purpose of convenience and manipulation (Delgado & Stefancic, 2001). What we are aware of is that people share characteristics according to their physical appearance, skin color, etc. While this holds true, we cannot group outward characteristics to behavior, brain intelligence, or personality. A lot of what happens in our society is not based on what we know scientifically, but more on what man created in relation to race.

As with most things of the world, not everything remains the same and there are constant changes. Differential racialization is a concept that describes how dominant racial groups assign meanings to expectations, behaviors, and norms (Delgado &

Stefancic, 2001). Furthermore, the patterns will aim to highlight or minimize a race at any time. The theory contains a belief that there is intersectionality within races. Intersectionality addresses how various forms of inequality and identity relate in different contexts over time (Gillborn, 2015). An example of this would be a woman who identifies as an African American, Christian, single mother, and activist. What this concludes from an intersectionality perspective is that individuals from different races have overlapping identities (Delgado & Stefancic, 2001).

Minorities speak and represent minorities is a concept within CRT that states that the voice of minorities should only come from the mouths of minorities (Bell, 2009). The idea is that historically there have been racial experiences resulting in oppression. Therefore, hearing about these experiences from the group who formulated the oppression would not provide a realistic viewpoint as it would from an individual who went through the oppression (Graham, Brown-Jeffy, Aronson, & Stephens, 2011).

CRT pays close attention to the experiences and knowledge of minorities to understand the effects of race relations. Obtaining this knowledge assists in society's ability to understand how racism directly and indirectly affects minorities. CRT views racism as an individual and overall experience that contains many levels (Bell, 2009). The theory provides a platform to identify the layers and the effects as well as viewing racism as an institutional and systematic occurrence (Graham et al., 2011).

The component of adding voice is a solid addition to increasing the narrative of minorities. The goal is to adopt a deeper understanding of the minority experiences that are relative to specific events or experiences (Taliaferro, Casstevens, & Gunby, 2013).

Although it is self-reporting, obtaining this data has value from our ability to know first-hand the experiences and the aftermath. The concept of storytelling is related to African American cultural traditions. It is a tool used for sharing information within a shared community (Graham et al., 2011). CRT is diverse from different multicultural approaches by not solely focusing on counternarratives but to focus attention on the voices of the oppressed. Oppressed voices offer the ability to counter assertive perspectives (Ledesma & Calderon, 2015).

CRT benefits from storytelling to describe series of events. The reality of what it is like to be a person of color has the ability to be told through the use of storytelling. This method shies away from providing an overarching theme but allows the individual to provide more of a personal testimony (Masko, 2005).

CRT in Mental Health Research

A primary goal of CRT is to view and communicate how placing race in categories benefits the majority and the consequences associated with everyday life (Brown, 2008). There has been little attention focusing on how minorities are stressed due to discrimination from being stigmatized. There has been curiosity in research about the effects of racism and whether it enhances or shields the mental health of European Americans (Brown, 2008). Analyzing CRT in mental health is for the purpose of acknowledging racial experiences within research and practice. It is important to challenge the current traditions, concepts, and theories on race in order to reveal the way minorities are affected by the field as it stands. Comprehension of the CRT framework provides a level of insight regarding how to offer help and minimize harm to minorities.

Clinicians can use CRT to explore the way racialized experiences can and have affected the African American worldview (Lee, 2018).

The belief that racism is ordinary and the societal hierarchy of whites above minorities is critical in the theory development. CRT has a responsibility to view how race and mental health are linear due to racial stratification (Delgado & Stefancic, 2001). Literature suggests several reasons there are challenges for minorities seeking mental health including expression of anger, and racial paranoia (Graham et al., 2011). The assumption is that addressing mental health concerns that are recognized and those who are unknown require a great deal of consciousness to the results of racial stratification (Graham et al., 2011).

Critical race theorists can offer a multitude of approaches towards understanding the significance of race on issues pertaining to the field of mental health. A theorist could take a look at the current circumstances of society (that includes crime rates, socioeconomic status, and poverty) as well a risk factors that includes discrimination. These factors can result in faulty psychosocial health. A CRT theorist might also assess different reactions to mental health as a result from minority categorization (Graham et al., 2011). Using CRT to analyze black mental health disparities is appropriate because it gives light to a marginalized race. CRT helps minority perspectives to be heard, amplified, and shed light on the historical perspective that is not always discussed in research (Ledesma & Calderon, 2015).

A subject matter featured in CRT is the belief that certain establishment's foundations are based on certain values that are not diverse across cultures or with no

regard to racial circumstances. These establishments can include, but are not limited to, churches, facilities of healthcare, government, family, and community-based organizations (Graham et al., 2011). The establishments more than likely contain dominant customs that are culturally universal. The universal customs typically determine the insiders from the outsiders; determining an individual's acceptance into the cultural establishment (Graham et al., 2011). CRT tries to deconstruct whiteness. Whiteness consists of a system that is embedded in social, economic, political, and cultural history that has conditioned institutions to provide white privilege and white dominance over any other racial group (Crichlow, 2015).This theory fights to address and interrupt white supremacy as the norm in societal, educational, and legal structures. The purpose is to minimize inequality across multiple platforms (Crichlow, 2015).

Dissecting the field of mental health from a critical race perspective brings light to the ways in which racism and inequalities alter the beginning stages of psychopathology and become the root causes of mental illness. In order to address what we know and the steps the field is taking towards change, the field should implement *post-psychiatry*. Post-psychiatry is defined as doing research that is aligned with society's form of inequalities and the harm it has caused. Incorporating CRT in minority mental health research spreads awareness relative to biases, assumptions, and privileges (Brown, 2008).

History of Mental Health in the African American Community

Although mental health is working on becoming more racially inclusive, reluctant mindsets regarding intentions and culturally sensitive practices still exist. What does this

look like? When one thinks of the face of the mental health field, you think older, white, and male (Brown, 2003). It is unlikely that a diverse group of individuals represent the history of mental health.

This poses a problem with attendance or participation in seeking mental health treatment. Outside of therapeutic distrust, there is societal distrust. The practices and history of racism trigger African Americans. The African American community is not willing to freely integrate mental health services if it means they will feel controlled by the white man and not have power over their lives and/or mental health.

It is no secret that there are difficulties bridging the gap between the African American community and mental health. What research has discovered is that part of the difficulties stem from lack of access to treatment as well as culturally competent health care providers. In the past, prejudice and overt racism has been present in the mental health field towards people of color (Vance, 2019).

At the center of all things racist and classist within the healthcare category, African Americans mental health needs are either not taken seriously, used as experimentation, or essentially unfulfilled (Thurston & Phares, 2008). There are factors such as oppression, racism, or terrorism that should not be overlooked when it comes to how African Americans are affected and thus negates mental health services. Literature argues that the socioeconomic status heightens the chance of mental illness, however, there is a wedge that prohibits either acknowledgment or acceptance that services are necessary (Mayfield, 1972). Slavery ended legally over a century ago, however, its impact has affected African American psychological well-being. From a national view,

African Americans have had their share of adverse, traumatic, race-related events occur. America is a nation that values grief, yet there appears to be minimal acceptance for African Americans to mourn their history. A century later, African Americans' mental health carries the weight of historical scars, inferiority, and difficulty with self-identity (Williams-Washington & Mills, 2018).

Mental health diagnoses see no color, race, identity, or gender; the onset of mental illness can happen to anyone. Although mental illness has no bias, how an individual learns about mental illness and/or copes with the diagnosis can vary tremendously (Keen, Whitehead, Clifford, Rose, & Latimer, 2014). While everyone is susceptible to mental health issues, African Americans experience heightened mental health conditions because of lack of access and other obstacles. Obstacles can include socioeconomic status that results in societal exclusion from resources such as mental health (Keen et al., 2014).

Minorities experience a large number of inequalities in mental health. Research indicates that some of these disparities resulted in services less available to African Americans, minimal access to service, and inadequate treatment (Thurston & Phares, 2008). The higher the cultural mistrust, the underutilization of mental health services in minorities. These factors result in untreated symptoms and an increase in stigma because of mistrust and fear of treatment and or racial discrimination (Thurston & Phares, 2008). Trauma exerts a heighted risk of mental health problems that can ignite changes to a person's mental health. In addition to cognitive impairment in how minorities see the world, these experiences and memories can impact the way African Americans see themselves, social environments, and determine the way they cope with adversity of life.

These factors lead back to mental health inequalities seen in the Tuskegee experiment (Williams-Washington & Mills, 2018). A change in the current stigma could change the history of minority mental health as we know it. African Americans' mental health is suffering significantly. Understanding the stigma and barriers can ignite the blueprint for change.

Barriers to Mental Healthcare in the African American Community

The focus on mental health in minorities has risen in the last decade with the understanding that there are gaps related to racial inequalities. Affordable Healthcare can be pricey, particularly services that include mental health treatment. Often uninsured individuals are given less than efficient services. Research has shown the levels of discrimination and overt racism in the health care field. People who fit into the low socioeconomic status report that they receive low quality care from mental health professionals. Insurance and financial resources as a barrier display how minority populations are often the group of individuals that struggle with the idea of seeking therapy (Chandler, 2019). Comprehension on the inequalities in mental health can further explain the attitudes by minorities. Discernment can create tailored interventions relative to treatment barriers. Negative attitudes are connected to the lack of changes even if minority voices are heard (Williams-Washington & Mills, 2018). Literature has focused attention to the treatment differences in the minority populations to include African Americans, Indian Americans, Latinos, and Asian Americans.

African American adolescents' interactions with racism and discrimination serve as triggers to their mental health, as well as their social and emotional development.

Symptoms of distress, low self-esteem, and anger can develop as a result of racial discrimination. These teens struggle with understanding how to cope, or even understanding the mental health sources that are available (Farzana & Lambert, 2016). African Americans parents' attitudes about mental health can determine their endorsement to their child seeking services. Some African American parents have a negative perception, leaving this as a barrier for mental health care for their child (Young & Rabiner, 2015). The impact of distrust towards mental health professionals is directly connected to the underuse of services. The level of mistrust can be based on past experiences, but it can also be learned behavior culturally. Distrust is also known to come as a response to discrimination and overt racism. Identifying the perspectives of the patient can inadvertently improve trust and the quality of care for African Americans (Cuevas, O'Brien, & Somnath, 2016).

Insurance and healthcare costs are important to dissect when viewing an individual's likelihood to partake in services. Statistics show that the average cost for an individual utilizing mental health services were $1000-$1500 out of pocket (Bijal et al., 2019). This large amount would pose as a financial burden for a minority in a poverty-stricken area. From the view of practitioners and clinicians, they have sometimes failed to address African American preferences or comfort to receiving treatment. Preferences include time spent with their providers, trust in their providers, and at times whether they share the same minority background (Pieterse, Todd, Neville, & Carter, 2012).

When seeking mental health services, terminology and meaning are essential. In the African American community, the term *psychotherapy* was closely associated with the stigma or mental illness (Thompson et al., 2004). *Reluctance* in this context refers to individuals in the African American community who are skeptical of seeking therapy due to barriers and the therapist's cultural competence. Using the term *counseling* was associated with the concept of problem solving as a result of conflicts (i.e., relationships, money conflicts, loss of job, marriage, etc.) rather than a mental illness intervention (Thompson et al., 2004). Attitudes towards mental health serve as another barrier to seeking mental health treatment. Reluctance and stigma towards mental health can carry a lot of weight, leaving accessing treatment minimally encouraged. African Americans who carry the burden of fear are 2.5 times greater than Caucasians to not initiate therapeutic services (Pieterse et al., 2012).

Cultural issues and stigma towards treatment, poor service, and attitudes towards treatment, account for the differing racial percentages in treatment engagement and retention. Some researchers have reported that there could be a connection between racial status and style of therapy on commitment to treatment. For example, Castro et al. (2005) argued that the structured interventions have not been empirically tested with minority populations. They report that they are not culturally sensitive and, therefore, may not connect with African Americans or any other minority race (Castro et al., 2015). In relation to seeking therapeutic services, mental health services relate to feelings of indignity and humiliation that create a barrier in the African American community

(Thompson et al., 2004). Stigma is a dishonor associated with a person, place, or thing. Stigma is apparent within the African American community through the negative opinions about individuals who seek therapy, the fear of being labeled, and the viewpoint that these services are not a helpful resource (Hall & Sandberg, 2011).

Access to Mental Healthcare

Access is defined as having the means using insurance to utilize mental health services. The focus is on whether African Americans have insurance and whether their policy covers mental health needs. The African American community lacks understanding regarding mental health coverage; therefore, it is unclear how to access treatment. Socioeconomic factors play a role in making treatment options less available.

Insurance

Insurance describes a means of obtaining mental health coverage whether through employment or public health programming such as Medicaid. Insurance companies have not made it known or advertised that mental health is covered through the healthcare policies. Laws have been ordered that increase and prioritize mental health. In detail, the law ensures that insurance policies include mental health resources. However, not all insurance carriers are knowledgeable about their policies and coverage (Chandler, 2019). Ethnic and racial differences in mental health insurance account for the differences in access to seeking treatment. The inequalities of insurance create difficulties in finding and keeping insurance (Sohn, 2017). When describing lack of insurance, it is also important to understand that minorities who do have insurance are not always knowledgeable that mental health is covered (Chandler, 2019).

African Americans not only have the lowest rate of health insurance, but they are also considered the least healthy racial group in America (Sohn, 2017). When comparing African Americans to Caucasians in 2017, 55.5% of African Americans used private health insurance to 75.4% of Caucasians (U.S. Department of Health and Human Services Minority Health Research, 2017). Prior to changes in the healthcare system, Medicaid covered approximately 21% of African Americans. Medicaid has subsidized treatment and served as a resource for minorities on services such as mental health. This insurance resource also serves as minimizing disparities to African Americans utilizing mental health (Murry et al., 2011). In 2017, 43.9% of African Americans utilized Medicaid or public health insurance. Lastly, 9.9% of African Americans in comparison to 5.9% of Caucasians did not have health insurance (U.S Department of Health and Human Services, Minority Health Research, 2017).

For decades, there have been evidence-showing differences between races pertaining to the access and outcomes of mental health treatment (Sohn, 2017). Minorities suffer the most; however, it is expected that insurance expansion will increase mental health access while minimizing disparities (Alegria, et al., 2012). When minorities participate in any form of treatment, it typically begins with primary care. Primary care physicians (PCP) are then used for multiple purposes that result in individuals left undiagnosed or overlooked mental health disorders (Sanchez, Ybarra, Chapa, & Martinez, 2014). Limited or no access to mental health specialists, cost, and insurance barriers are connected to relying on a PCP for adequate services (Sanchez et al., 2014).

Reluctance can occur when minorities are aware that there is limited access in their neighborhoods or in low economic status areas. However, other factors such as lack of insurance, religion, compatible providers, and other cultural practices strengthen the likelihood that minorities will not utilize mental health services (Ailshire & Garcia, 2018). When grouping race and poverty into one equation, there are high percentages that both categories will lack resources that will enhance their mental health. The lack of resources increases mental health related symptoms to the community as a whole. Minority individuals are more likely to live in areas where there is little to no mental health presence. Although all ages are affected, poorly resourced areas can result in negative mental health outcomes (Ailshire & Garcia, 2018). Literature on the effects of neighborhoods provides a perspective to how individuals can be affected. Minorities are at times unconscious as to how their environment affects their mental health. Increasing mental health awareness and presence at the community level can lessen adverse effects on an individual's mental health (Chun-Chung Chow et al., 2003).

Society has knowledge of the benefits of mental health services as well as the effects of individuals who lack these services as a resource; yet, there is little evidence that action has been done to solve these concerns (Lee, 2005). Mental health training has concluded that practices such as CBT and psychotherapy are effective treatment approaches, but these treatments are inconsistent with African Americans who are less likely to be granted the opportunity (Lee, 2005).

Exposure to Mental Healthcare

Exposure defined will focus on how African Americans are influenced to either seek treatment through the use of gatekeepers or use the methods that are used outside of mental health treatment due to lack of exposure. Previous research has evaluated how often African Americans are exposed to the benefits, knowledge, and purpose of mental health (Neely-Fairbanks et al., 2018). Furthermore, exposure was assessed based on how or if gatekeepers influenced people of color to either participate in mental health or if their reluctance increased depending on their views.

Gatekeepers

According to Carr and West (2013), in rural communities some may think that pursuing therapy will make their neighbors think they are unbalanced. African Americans sometimes view therapy as pathetic and believe they should be able to handle their problems on their own, and consequently, they find substitutions to therapy (Carr & West, 2013). African Americans tend to rely on family, religion, and social communities for emotional support rather than turning to health care professionals, even though this may at times be necessary (Carr & West, 2013). One belief is that the appropriate way to handle family concerns is within the family. According to Carr and West (2013), it is frowned upon in the African American community to discuss private information to a person who has not earned their trust. African American men felt as if therapy could weaken their pride as they are seen as the protector and head of the household; and African American women felt that they must be the caregiver and source of strength in the family (Carr & West, 2013).

Mental health utilization is more likely to gain minority participation from the voices of community leaders, friends, teachers, etc. that report the effectiveness of mental health treatment. (Cushman, Clelland, & Hornby, 2011). The field of mental health will argue that gatekeepers who promote mental health services should be active in implementing and normalizing participation (Cushman et al., 2011). Influential groups and individuals can alter perspectives for African Americans who voice reluctance. Educating the community, having positive messages, and requesting testimonies from minorities with mental illness can effectively minimize the gap.

Religiosity

Religiosity is combined with both a spiritual and religious aspect. Spirituality is defined as a search for meaning in life, something bigger than ourselves, with room for multiple perspectives. Religion is measured by a participant's belief in God or in many gods whether formal or informal. The concept of religion is an impactful tradition in the African American community where individuals seek guidance within the church as a means of social support (Breland-Noble, et al., 2006). Religion in the African American community serves as a protective mechanism for individuals and families. The church and/or religion appears more consistent than the field of mental health. Religion is an important aspect in the African American community and a potential barrier to seeking therapy.

The church is considered the backbone of the African American community. Messages and persuasive language are spoken weekly from their trusted leaders. Leaders in the church have advanced in the types of messages that are delivered from the pulpit to

include politics, social justice, and mental health. The church continues to be a gateway to reach and mobilize African Americans for meaningful reform (Brewer & Williams, 2019).

Historical progression has advanced the priorities in the African American church to now address concerns of mental health. Leaders are aware of their influence on the African American community as well as their ability to alter negative beliefs towards members who are suffering silently. The goals in the church are to promote positive attitudes and encourage initiatives towards psychological well-being in conjunction with spiritual well-being (Brewer & Williams, 2019).

The belief that God will save individuals from all mental illness is an adopted perspective within religion. Anything contrary to this belief could result in compromised faith. (Kelly et. al, 2013). In times of despair, the African American community depend on the leadership of pastors, reverends, or bishops. Relying on religious leaders helps to reaffirm the perspective that God can solve all problems, including mental health.

As society advances, so does the message within spirituality and religion. Religion and spirituality are avenues that influence the minority population. Churches and community leaders who promote the acceptance of mental health have been found to encourage action from trusting members (Cushman et al., 2011).

Mental Health Barriers

African Americans' trust in the system has been compromised that starts with the mockery of health care that was provided compared to Caucasian people (Vance, 2019). There is evidence of historical discrimination that results in an inability to access

sufficient health care, mediocre insurance, minimal financial opportunities, as well as discrimination from providers. While there are perspectives that history repeats itself, the African American community fears whether active participation is in their best interest. Historically, the African American community was and continues to be disadvantaged in mental health through subjection to trauma through enslavement, oppression, colonialism, racism, and segregation.

The Tuskegee Experiment is one of the most traumatic and wounding studies conducted in America. The official name is considered The Tuskegee Study of Untreated Syphilis in the Negro male, where researchers performed a 40-year experiment run by the Public Health Service (Alsan & Wanamaker, 2017). These individuals studied and followed 600 African American men in Alabama who had a syphilis diagnosis. These individuals failed to report to these African American men that they contracted this sexually transmitted disease and refused to provide them with treatment.

Informants finally brought the study to an end in 1972 due to the unethical practices, which influenced the beginning of modern medical ethics. However, even after shutting the study down, the lives of the African American men were ruined. A large number of African American men died from the disease, and the women and children of these men also contracted the disease (Alsan & Wanamaker, 2017). It is said that "The Tuskegee Study became a symbol of their mistreatment by the medical establishment, a metaphor for deceit, conspiracy, malpractice, and neglect, if not outright genocide" (Corbie-Smith, Thomas, Williams, & Moody-Ayers, 1999, p. 537).

African Americans are not shy in expressing their distrust for medical professionals and the field of mental health. African Americans' voices are strong in describing how they have been stigmatized in this field. People of color share perspectives in conspiracy beliefs and are typically less likely to have a constructive experience in a mental health atmosphere. The history of exploitation, slavery, Tuskegee, and misfortunes are all factors that guide the African American mindset of being exploited rather than trusting the White man in a white coat (Alsan & Wanamaker, 2017).

Two words to describe the history of African American mental health in the United States are troubled and disturbing. Historical factors contribute to the descriptive factors and lack of action to seek therapeutic services. The mental health of African Americans has been compromised as early as slavery with the acts of experimentation. The experiments aimed to study pain effects by burning slaves alive or in some cases they were operated on to accentuate psychological differences to infer African Americans were inferior. The aim was to portray them as less than to justify societal acts of inequality, subjugation, and exploitation (McGee & Stovall, 2015).

W. E. B. Du Bois' (1915) viewpoint was that due to the years of slavery and oppression, African Americans retained negative memories and experiences that influenced the foundation of their culture (McGee & Stovall, 2015). The battle today is the struggle between the African American culture and the culture of society. There appears to be confusion with how African Americans identify as an aftermath to classism, racism, and sexism. The societal push is for minorities to conform to what they deem as the primary American identity; that ultimately produces split loyalty between their ethnic

identity and the dominant identity (McGee & Stovall, 2015). Society has failed to address the overt stigma or lack of change in the system, even when there has been research explaining reluctance in African Americans.

Past and present literature on mental health reports that African Americans have a higher rate of mental illness compared to the majority population. This concluded that African Americans were described as being severely mentally ill and European Americans were labeled as obtaining varying ailments of mental illness (McGee & Stovall, 2015). Examples as such could influence mental health or diminish the perspective due to the impact of race and racism (Brown, 2008). One must work to unravel cultural influences, race, and ethnicity to fully understand the magnitude of race and ethnic behaviors in their status of mental health (Brown, 2008).

Some studies that focus on understanding minorities and mental health report that African Americans are resilient and have an innate response to coping on their own that they are unharmed by the world's stressors (Brown, 2008). While there might be forms of resiliency within the African American community, there are also other ways African Americans cope outside of a therapeutic setting. Outside coping mechanisms could include addressing those who exercise racist behavior, leaning on spiritual or religious belief systems, and having an understanding relative to how race and racism operate in our society. The determinants of minority mental health are driven by individuals who have different interpretations of symptoms that stem from sociocultural factors (Brown, 2008). Brown (2008) explained that communities have the power to define what is considered normal and abnormal in relation to mental health diagnoses. What one will

find is that for years there has been an oversight of the experiences and results of race and racism; resulting in a jaded perception of psychological dysfunction. A critical race theorist would debate that minority groups are competent enough to report how race and racism has influenced utilization of mental health (Brown, 2008).

With all of the information obtained about the barriers that hinder minorities from seeking mental health services, it has been suggested that marriage and family therapists increase their racial awareness and enhance their cultural sensitivity. An additional layer would be for the training and supervision to shift focus towards race and racism. Lastly, the field needs to be more racially diverse. A strategy that would lessen assumptions and possibly decrease barriers would be to administer a self-report and ask racial and ethnic minorities what mental health and illness means to them and the community. This is another necessity to research what symptoms determine an individual who is suffering from mental illness to seek treatment (Boyd, 2018).

Seeking Mental Health Treatment

African Americans have participated in mental health services currently and in the past; they have also spoken about reasons why they discontinued services or seeking treatment. Common themes from the African American community begin with their inability to trust white professionals. Additionally, financial reasons, location, and lack of awareness also pose as barriers. To increase retention and behaviors, the mental health field needs to become more racially inclusive, addressing stigma, attitudes, and adversity through the African American lens (Cuevas et al., 2016). Cultural competency can have a major impact when addressing barriers. African Americans who experience one or more

of these barriers tend to rely on other community resources that might not address mental health (Chandler, 2019). There is also limited research that assists in addressing or explaining the mental health issues in the African American community. It is important to first understand African American dynamics. Investigating these barriers to treatment can assist clinicians in their levels of cultural understanding that could need to innovate ideas to merge the gap (Chandler, 2019).

An alternate viewpoint that is found in literature is that African Americans who have mental health providers who are also African American are able to accept reasons to attend therapy, participate in suggested interventions, and understand the benefits of therapy. However, this preference for same race therapist is not always met due to the low statistic of African American therapists. Only 10% of African American participants see a therapist of the same race, according to the National Survey of Black Mental Health (Taliaferro et al., 2013).

As much as society hates to admit, we must recognize that we are not living in a post racial society. Racism is everywhere and is either overtly or unconsciously seen within mental health. Although there are only 10% of minority individuals who have a therapist that looks like them, it does not mean that the only way to increase utilization is to solicit more African American therapists (Taliaferro et al., 2013). Research suggests that minorities view treatment as a last resort, leaving the low percentages as explanation to their lack of participation. African Americans report economic issues, poor access to health care, and provider mistrust as reasons for the use of alternate treatment measures (Castro et al., 2015). What is needed is self and racial awareness. Both Caucasian and

African Americans can work to understand self and racial awareness in order to become more autonomous, have a positive racial identity, and actively support an antiracist proposition that will include continuing to examine one's mindset and learn how to be effective in a multiracial atmosphere (Taliaferro et al., 2013).

Advocating for social justice will provide a call for action within the community, the church, the education system, and the entire minority population. The more we know about an individual's worldviews, the more we can make an impact to minimize negative perspectives (McDowell & Jeris, 2004). African Americans report that experiences of perceived discrimination are also associated with low quality treatment. Although there is literature that reports experiences of discrimination directly affects the health care experience, there is limited information about the direct aspects' minorities find discriminatory. Comprehending the factors that African Americans find unfair or discriminatory can assist mental health clinicians to be more successful in increasing treatment (Cuevas et al., 2016). A number of advocates can work to address individual acts of racism by encouraging minorities to share and express stories of strength as well as openly talking about the history of race relationships and discrimination acts in society (McDowell & Jeris, 2004).

Mental health providers can use tools such as genograms to focus on themes of strength and perseverance, and provide a platform for minorities to speak openly about their personal experience instead of the conscious "no racial talk" that silences and creates tension diminishing the possibility to process your feelings of discrimination. McDowell and Jeris (2004) Genograms are therapeutic tools used by clinicians to assess

history of behavioral patterns in a family across generations (McDowell & Jeris, 2004). Another angle would be to minimize barriers by speaking the same language as the client (i.e., native language); knowing the appropriate time to discuss race in the therapy room and assisting clients to assimilate without losing their culture or traditions. The field of mental health will benefit from listening to the untold, silence, and voices of color (McDowell & Jeris, 2004). There have been various results when studying African American beliefs and attitudes about mental illness and seeking treatment. One perspective has shown that in relation to mental illness, African Americans report that it is stigmatizing. This perspective results in low treatment-seeking (Neely-Fairbanks et al., 2018).

In contrast to the stigmatizing perspective, African American studies have reported positive beliefs and attitudes towards seeking mental health. However, in some research results the alternative perspective is not conclusive to seeking treatment. For example, when relating perceptions of treatment effectiveness to mental health, African Americans were more likely than Caucasians to accept that mental health providers are effective with mental illness. African Americans also believed that although effective, mental health issues can improve on their own (Ward et al., 2014). African Americans tend to place more emphasis on alternative treatments to mental health than utilizing services. The importance is place on other forms of coping or alternatives to therapy such as prayer or relying on self for a resolution (Castro et al., 2015).

Adopting the viewpoint that mental health issues can resolve on their own served as a coping skill and minimized the action step of participating in mental health services.

In a study that compared racial differences in attitudes toward professional mental health care, African Americans were higher than Caucasians in positive attitudes, yet less likely to utilize services (Ward et al., 2014). Additionally, there are other barriers that create reluctance. African Americans are cautious of diagnoses and treatment plans conducted by Caucasian providers. Minorities are skeptical about the accuracy of a diagnosis or treatment plan if the provider lacks cultural competency (Hawkins, Watkins, Bonner, & Thompson, 2016).

Bringing light to white being the norm and white privilege is the shift that needs to take place in the field of marriage and family therapy in order to better benefit the African American community. Questions such as 1) Do individuals of all color have a strong presence and voice? 2) Is there room to discuss experiences? 3) Are we bridging the gap and incorporating other individuals to advocate for minority inclusion? can help to alleviate some reservations African Americans have about therapy (McDowell & Jeris, 2004). Utilizing the tools suggested will encompass the ability to not only educate but empower African Americans to seek mental illness treatment.

CHAPTER III

METHODOLOGY

Sample

The proposed study used data from the Collaborative Psychiatric Epidemiology Surveys (CPES) 2001-2003 secondary data set (Alegria, Jackson, Kessler, & Takeuchi, 2003). The CPES collected extensive data on the use of a wide range of mental health services. CPES examined participants who received mental health related services or reasons why they excluded themselves from seeking help. The data collected sought to understand the correlation and risk factors pertaining to mental health amongst minorities. A goal of CPES was to gather data that includes discrimination and assimilation for the purpose of understanding how mental health is linked to social and cultural issues. Originally, the study included 4,476 African American participants. The current study used a subsample of African American participants who responded to questions relative to mental health. The final subsample included 534 African American participants, which provided a unique opportunity to understand the African American perspective on mental health (Alegria et al., 2003).

Measures

Insurance Access

Access to insurance was measured using two items. Participants were asked to respond *yes* or *no*, to the following questions: "Are you covered by insurance that covers mental health/emotional/nerve problems" and "Are you covered by government

insurance that covers treatment problems with emotions, nerves, or mental health." Items were dichotomized in order to enter the data; yes answers were coded as 1, and no answers were coded as 0.

Exposure: Gatekeepers

Gatekeepers were measured using three items. Participants were asked to respond *yes* or *no* to the following statements: "Did a spiritual advisor ever recommend that you go to a mental health specialist, clinic or program?", "Did anyone encourage you or put pressure on you to see a professional about your emotions?", "Were you pressured to see a professional about your mental health in this past year?". Items were dichotomized in order to enter the data; yes answers were coded as 1, and no answers were coded as 0.

Mental Health Barriers

Barriers towards mental health treatment were measured using six items. When examining barriers for mental health, participants were asked to respond *yes* or *no,* to the following statements such as, "Reason delay treatment – problem would get better by itself", "Reason delay treatment – problem did not bother you", and "Reason did not get help- handle problem on their own". Remaining indicators can be found in Appendix A. Items were dichotomized in order to enter the data; yes answers were coded as 1, and no answers were coded as 0.

Seeking Mental Health Treatment

Behaviors toward seeking mental health treatment were measured using fourteen items. When examining behaviors to seeking mental health treatment participants were asked to respond *yes* or *no,* to statements such as: "Talked to psychiatrist about reactions

to an event?", "Talked to other mental health professional about reaction to event?, Talked to psychiatrist about problem?", "Talked to other mental health professional about problem? Talked to psychiatrist about worry?" "Talked to other mental health professional about worry?" Remaining indicators can be found in the Appendix. Items were dichotomized in order to enter the data; yes answers were coded as 1, no answers were coded as 0.

Religiosity

Religiosity was measured using two items. When examining religiosity participants were asked to respond to the following two statements, "How important is religion in your life? (Would you say that it is very important, fairly important, not too important or not important at all?)", "How important is spirituality in your life? (Would you say that it is very important, fairly important, not too important or not important at all?)". Both items were reverse coded, such that higher scores reflected greater religion/spirituality.

Data Analysis Plan

To examine the Research Question One, I conducted chi-square analyses to assess the associations between access and exposure and African Americans behavior to seeking mental health treatment. The independent variables included access to mental health treatment and exposure to mental health treatment, and the dependent variable was the behaviors to seeking mental health treatment. Following the chi-square analysis, a logistic regression was ran to predict whether religiosity and mental health barriers predict African Americans' behaviors towards utilizing mental health treatment.

Chi-square analyses were ran. The chi-square test is a statistical test that compares expected data with collected data. It indicated whether there is large difference between expected and collected numbers with a *p*-value (probability). The *p*-value was used to determine whether the null hypothesis should be accepted or rejected. The chi-square test analyzes the independence of two variables (Field, 2009).

A chi-square test is designed to analyze categorical data. That means that the data has been counted and divided into categories. The chi-square test for independence, also called Pearson's chi-square test or the chi-square test of association, was used to discover if there is a relationship between two categorical variables. To run the chi-square tests, the frequencies for each of the variables listed in the research question (access, exposure) were collected (Field, 2009).

In SPSS Statistics, two variables were created so that we could enter our data: Access and seeking mental health, as well as, exposure and seeking mental health. A total score was created that represented if they had any of these, they were listed as a 1, if not, they were listed as a 0.

To run the chi square in SPSS, I first clicked “analyze” and chose “descriptive statistics”, followed by “crosstabs” and continued by transferring one of the variables into the row(s) box and the other variable into the column(s) box. Next, I clicked on the statistics button. I was then presented with the following Crosstabs: Statistics dialogue box. The chi square and Phy and Cramer’s V option was selected. In the crosstabs cell dialogue box, I selected “observed” from the counts area, row, column, and total from the percentages area. The data is completed by clicking “ok” and generating the output.

The chi-square test was then run for Insurance Access covering mental health and whether participants participated in seeking mental Health. Another chi-square test was run for mental health exposure and whether African Americans participated in mental health. To minimize the effects of expected count violations for the one-way Chi-square analysis, each of the research questions was reduced to a binary value.

For Research Question Two, a logistic regression was run to test the hypothesis. Associations between religiosity and mental health barriers towards seeking mental health services were examined by conducting a logistic regression analysis. For the first step, religiosity was examined between behaviors towards seeking mental health services and mental health barriers were added with connection to religiosity and seeking mental health services in Step 2.

Strengths and Limitations

The strength of analyzing this dataset was that we were able to view the linear relationships and influences of access and exposure to mental health utilization. Along with viewing the relationships, we viewed the outliers that did not show an effect from one variable to the next. By running a chi-square and logistic regression, we are able to further understand the influence among variables to enhance the researcher's interpretations of the findings. One limitation in this data set was that the raters in the collection of research are Caucasian individuals and not diverse. The research was collected from 2001-2003, therefore the dataset might not be relevant to the current outcome of the dependent variable.

Chapter IV

RESULTS

The purpose of this study was to examine the risks and barriers associated with African Americans and mental health treatment. Specifically, this study attempted to identify if access and exposure influenced mental health attitudes, and to understand the stigma and barriers while also viewing how religiosity might affect help seeking behaviors in the African American community. This quantitative study used data from CPES to unpack how insurance, gatekeepers, barriers, and religiosity relate to the participation in mental health services. The remainder of this chapter presents the detailed analyses of secondary data provided by CPES 2001-2003. Results of this study are presented in this chapter and begin with demographics, then preliminary analyses (testing assumptions), and then a chi-square analysis of access and exposure on seeking mental health services. Lastly, a view of a logistic regression that presents data on the effects of religiosity and barriers on seeking mental health treatment is provided. In this chapter, the research hypotheses previously discussed will be addressed.

Research Hypotheses

Hypotheses for Research Question 1

(a) African Americans who have access will increase their behaviors towards utilizing mental health treatment; and (b) African Americans who have exposure will increase their behaviors towards utilizing mental health treatment.

Hypothesis for Research Question 2

Mental health barriers will moderate the relationship on religion and spirituality when determining African Americans' behaviors to utilizing mental health treatment.

Preliminary Results

Prior to calculating any descriptive and/or inferential statistical procedures, several variables in the dataset were recoded for purposes of this investigation. First, data on respondents other than African American participants were removed from analysis. Second, the indicators relative to the variable of access were merged. This merging permitted the creation of the access variable with two response options: had insurance that covered mental health and did not have insurance that covered mental health. Following these recoding procedures, frequencies were calculated on the number of African American participants in the two categories. The procedure mimicked itself for the variable of exposure that included merging the indicators relative to exposure and merging them together for a two-option response: African American participant was exposed or participants were exposed and did not seek mental health services.

Following these procedures, descriptive statistics were then calculated on the variables that constituted access and exposure. In the following tables, readers will be provided with frequencies and percentages for these items, reported separately by access and exposure. Readers should remember that these statistics were calculated on all African American participants.

Research Question 1 was: How does access (IV) and exposure (IV) to treatment affect African Americans' behaviors towards utilizing mental health treatment (DV)? This question had two hypotheses: (a) African Americans who have access will increase their behaviors towards utilizing mental health treatment; and (b) African Americans who have exposure will increase their behaviors towards utilizing mental health treatment.

To address the first hypothesis, Table 1 displays the chi-square test for the association between access to mental health services and seeking mental health. The overall test was significant, $\chi^2(1) = 128.01$, $p < .001$, Cramer's $V = .16$. Inspection of the table found that 17.5% of the respondents sought mental health treatment when they had access to mental health insurance compared to 6.9% who sought mental health services and they did not have mental health access. This combination of findings provided support the first hypothesis (see Table 1).

Table 1

Chi-Square Test for the Association Between Access and Seeking Mental Health

	Seeking Mental Health					
	Sought Mental Health		Did not seek Mental Health			
	N	%	*N*	%	χ^2	*p*
Access					128.01	*p*<.001
Did not cover mental health	195	6.9%	2614	93.1%		
Did cover mental health	339	17.5%	1598	82.5%		

Note. Cramer's *V*=.16.

To address the second hypothesis, Table 2 displays the chi-square test for the association between exposure to mental health services and seeking mental health. The

overall test was significant, $\chi^2(1) = 158.14$, $p <. 001$, Cramer's $V = .18$. Inspection of the table found that 35.1% of the respondents sought mental health treatment when they had been exposures to mental health compared to 9.9% who sought mental health services and they did not have mental health exposure. This combination of findings provided support for the second hypothesis (see Table 2).

Table 2

Chi-Square Test for the Association Between Exposure and Seeking Mental Health Services

	Seeking Mental Health					
	Sought Mental Health		Did not seek Mental Health			
	N	%	*N*	%	χ^2	*p*
Exposure					158.14	*p*<.001
Exposed	92	35.1%	170	64.9%		
Not Exposed	442	9.9%	4042	90.1%		

Note. Cramer's *V*=.18.

Research Question 2 was: Do mental health barriers and religiosity predict whether African Americans seek mental health treatment? The related hypothesis was: Mental health barriers and religiosity will predict whether African Americans increase their mental health treatment. To address this hypothesis, Table 3 displays the results of the logistic regression model predicting seeking mental health treatment based on mental health barriers and religiosity. The overall model was not significant, $\chi (1) = 3.33$, $p = .19$. This combination of findings provided support to reject the alternative hypothesis (see Table 3).

Table 3

Prediction of Seeking Mental Health Treatment Based on Barriers and Religiosity

							95% *CI*	
Variable	*B*	*SE*	Wald	df	*P*	*OR*	Lower	Upper
Religiosity	-0.48	0.46	1.09	1	.30	0.62	0.25	1.52
Mental Health Barriers	1.00	0.72	1.94	1	.16	2.71	0.67	11.07

Note. χ (1) = 3.33, p = .19.

Summary

In this chapter, the responses of African American participants who had either access or exposure towards mental health were addressed. Indicators were combined due to low sample size. The responses of predicting whether religiosity and mental health barriers affect African Americans from seeking mental health treatment was also addressed. Then, the two research hypotheses were addressed. With respect to the first research hypothesis, "African Americans who have access and exposure will increase their behaviors towards utilizing mental health treatment", the results of the statistical analysis did support this hypothesis. Regarding the second research hypothesis, "Mental health barriers and religiosity will predict whether African Americans seek mental health treatment," results were not supportive of this hypothesis.

CHAPTER V
DISCUSSION

This chapter presents a summary of the study, discussion of the findings, implications for practice, and recommendations for further research. The summary and discussion expand upon the concepts that were studied to provide an understanding of the impact of access, exposure, religiosity, and mental health barriers towards African Americans seeking mental health treatment.

The current study examined the associations between access and exposure towards behaviors seeking mental health treatment. A further analysis viewed whether religiosity and mental health barriers predicted African Americans' behaviors towards seeking mental health. Analyses only studied the African American participants to include 534.

Research Question 1

(1) How does access and exposure to treatment affect African Americans' behaviors towards utilizing mental health treatment?

The findings from Research Question 1 indicated that there was statistical significance in both access and exposure to seeking mental health services. These findings were supported by those of prior researchers regarding access and insurance.

Access

Access through insurance was used a variable to view how or if it influenced African Americans to seek mental health treatment. Insurance was shown as a barrier to

mental healthcare, with African Americans experiencing lower rates of insurance coverage compared to Caucasians (Brown et al., 2000). Minorities have lower rates in comparison to Caucasians; however, it is assumed that the insurance expansion will give African Americans an opportunity to have more access. In relation to the insurance expansion, there was an aim to examine two things: whether African Americans had insurance and whether the insurance covered mental health treatment. The literature reminds us that obtaining insurance is a key factor in deciding to seek treatment, but not the only determining factor (Chandler, 2019). We can conclude that insurance assists in eliminating disparities in the form of access, giving African Americans an opportunity to seek mental health treatment.

Results indicated significance in the form of access and African American behaviors towards seeking mental health care. This fits with the trend of both insurance and African American mental health care. Although African Americans as a race are the lowest ethnic group to have health insurance, as time passes, the percentage increases (Murry et al., 2011). This is similar to the trend in mental health. Mental health was not always wildly discussed, and societal advances have spoken about insurance related mental health access. Significance in with this variable aligns with the historical trends of both insurance and mental health. The data in this study were collected between 2001-2003. Changes to insurance have taken place, including more emphasis on mental health care. One of the major highlights of Obama's term was the Affordable Care Act, which increased the discussion of not just physical care, but also mental healthcare (Mende &

Mbah, 2020). Insurance access has increased in what is offered and how Americans' are using this resource for their mental health benefit (Mende & Mbah, 2020).

Exposure

Exposure was an opportunity to view how African Americans are influenced by encouragement, pressure, or recommendations through gatekeepers. Gatekeepers served as family, friends, community leaders, etc. Literature describes how historically African Americans trust the voices of individuals within their community. Decades of coping stemmed from working solely within the family system, community resources such as church, or left unaddressed. In connection to the results, the increase in mental health utilization is connected to gatekeepers who promote mental health services as a beneficial resource (Cushman et al., 2011). The research was aiming to find out whether voices of the community can alter reluctance or increase exposure to treatment.

Overall, the current study did find significant results when analyzing whether access and exposure was significantly related to African Americans' behaviors to seeking mental health treatment. With a number of differing perspectives, humans have influence both positively and negatively about a multitude of topics. Within the African American community, they are influenced by both the culture and cultural perspective (Graham et al., 2011). The results are significant and are conclusive to the hypothesis due to African Americans receiving pressure or encouragement from trusted individuals about mental health care. African Americans appear more likely to take action to obtaining mental health if they are encouraged by someone they trust due to historical trauma and carelessness towards the minority race. Perceptions of mental health care during data

collection (2001-2003), nearly 20 years ago, has fluctuated in the African American population. Although there was a shift beginning, the shift continued to increase involving more conversations that surrounded taking action towards mental health utilization.

Research Question 2

(1) Do mental health barriers and religiosity predict whether African Americans seek mental health treatment?

The findings from Research Question 2 indicated that there was no statistical significance in predicting whether mental health barriers and religiosity influenced African Americans behaviors to seek mental health treatment.

Religion

Past research matches the hypothesis that religion will affect African American behaviors towards seeking mental health treatment. What was understood from research was that the church is considered the backbone of the African American community (Brewer & Williams, 2019). However, historical progression has advanced the priorities in the African American church to now address concerns of mental health. Leaders are aware of their influence on the African American community as well as their ability to alter negative beliefs towards members who are suffering silently (Brewer & Williams, 2019). This perspective displays why there was no significance in that religion is not viewed as a predictor for mental health in African Americans. As society advances, so does the message within spirituality and religion. Religion and spirituality are avenues that influence the minority population. Churches and community leaders who promote

the acceptance of mental health have been found to encourage action from trusting members (Cushman et al., 2011).

CRT focuses attention on the foundations of establishments that hold strict values that are not diverse amongst differing cultures or place emphasis on racial situations. Churches, healthcare facilities, family, government, and other community-based facilities are establishments that are likely to include dominant customs that are culturally universal (Graham et al., 2011). The dominant customs within these establishments typically uncover the insiders from outsiders while determining who gains acceptance into these cultural establishments (Graham et al., 2011). The results form a different perspective than the one featured in CRT. A universal stigma included the reliability of religion as a sole mental health resource. The results found no connection between religious involvement and mental health. The growth and transitional perspectives are minimizing religion from being as strong of a barrier as it has been in the past. Religiosity continues to be a safe haven for African Americans, however, taking care of their mental health in conjunction with active religiosity is accepted and now talked about where it was once silenced in this environment. The growth and shifts explain why the analysis does not fit with the hypothesis. Present day discussion about religion does not separate the two components but merges them. Religion is viewed as a resource and a means of coping, similar to what is being "preached" to the African American community.

Mental Health Barriers

It was hypothesized that barriers towards mental health would predict behaviors in African Americans towards mental health; however, the research found no significance. The results are not revealing of the research regarding mental health utilization in conjunction with societal and mental barriers. African American research discusses that there has been a lack trust in the system, as well as whether treatment is effective (Vance, 2019). While there are perspectives that history repeats itself, the African American community feared whether active participation is in their best interest. Perspectives that the problem would dissipate on its own or a worry of what others might think are indicative of the indicators presented in this study.

The gap in this research includes when this data was collected and the present-day perspective. Research has begun to pride African Americans on their resiliency without the resources of mental health. While there might be forms of resiliency within the African American community, there are also other ways African Americans cope outside of a therapeutic setting. There was an assumption that barriers hindered and/or influenced reluctance.

CRT would argue the point that minorities are competently capable to articulate how race and racism has determined their actions related to mental health utilization (Brown, 2008). This perspective fits the mold of the results provided. That as society has grown mentally, so has the entire race of African Americans. It does not mean that these barriers are not still in place due to active and overt racism, but it does mean that African Americans are seeking mental health despite these factors.

It is concluded from the results that it is used as a caution more than a barrier. Caution in ways that a minority could recognize and view red flags in the mental health field or when they are involved with a therapist. The red flags are protective mechanisms but not such a stronghold that is hindering African American behaviors towards mental health. Therefore, the current study did not support the hypothesis that barriers are significantly associated with African Americans' use of mental health treatment.

Seeking Mental Health Treatment

Both research questions and hypotheses focused on variables that influenced or did not influence African American behaviors towards utilizing mental health treatment. Hypothesis 1 showed results that signified behaviors towards treatment, whereas, Hypothesis 2 did not influence behavioral actions. Research is diverse in both perspectives showing reasons African Americans are reluctant or more open minded.

African Americans have participated in mental health services both currently and in the past; they have also spoken about reasons why they discontinued services or sought treatment. Behaviors are influenced by many attributes and one perspective cannot be generalized across behaviors that minorities will take. There is research that fits with both hypotheses listed. Within this research, it is concluded that the changes and transitions in society are creating changes culturally. As previously mentioned, this data was gathered between the years of 2001-2003. The results are related to the era in which the data was collected. Certain factors such as age, education, and background can alter a participant's response. Again, it is important to know and understand African American history, with the understanding that the stigma that African Americans had, is less reluctance and more

curious. The significant findings related to access and exposure individually implicate that the more African Americans have one of these variables, the more an African American might be willing to seek treatment. Understanding that barriers and religion are not indicative of behaviors are not cohesive with past research but instead show how the societal trends can influence research findings.

Limitations

There were several limitations to the current study. First, the measures lacked specificity potentially leading to divergent interpretations of the items by participants. For example, religiosity was measured by asking participants how important is religion in their life? There are other ways to measure religiosity, also noting that religion is measured differently in different types of research. Having a set way to define these variables would be beneficial to future research. Across the variables included, only a subset of participants answered the questions. The research included a total of 4,473 African Americans, however, only 534 participants were used for the data collection. If we had different variables that included more than just a yes or no, we could draw more conclusions and possibly have different results in future research.

Secondly, the measures were altered to be dichotomous, therefore lacking adequate variance for more sophisticated analyses. The research did not have the best tools to measure the variables and the measures themselves were not great due to many binary variables. However, we acknowledge that it is a limitation. Dichotomous variables are difficult to find significant results because everyone is in the same group. There are individual differences within the group, but they are treated as if they are the same.

Having a huge data set is a positive addition to the research, yet the numbers were low for the indicators used. This is exploratory research. The objective was to see if relationships existed in the dataset. Future research can include better measures to view these items. For example, the barrier measures did not adequately represent the research related to African American barriers to mental health treatment. A large amount of research describes the race of the therapist as a barrier; yet, it was not measured in this dataset. The most effective future research would be one that collected their own data with the inclusion of detailed questions to these variables. For the purposes of this current study, that option was not possible.

Implications for Future Research

The findings of this research have key implications for clinicians, educators, families, and researchers. Clinicians can utilize this research to understand the differences that access and exposure have on African Americans behaviors towards seeking mental health treatment. As a clinician, it should be a goal to increase awareness and educate through exposure and access. More specifically, clinicians can help minority families, increase knowledge in the community and minimize the stigma that has been created historically. We can assume that if there are areas where African Americans are not open to the idea of therapy, there is a lack of access and exposure.

The current study also has implications for educators. Within the field of education, continued work goes into preventative care and action plans. Educators are passionate about parental education and spreading knowledge in the family education

criteria. Updating the curriculums and including statistical data relative to mental health is another facet that can benefit the education field.

This information is pivotal for family therapists in practice. Continued education can assist all clinicians with new findings pertaining to African Americans and increase their cultural competency. First, future researchers could continue this work and examine these variables in other snapshots in time. For example, it would be interesting to see how or if the results change throughout the lifespan, or if they stay consistent.

Counseling and family therapy programs can use this information to ensure their students are knowledgeable and culturally competent. Specifically, university programs can challenge their students to grow outside of their comfort zone to view how they can be a part of the solution and not a part of the problem. When students reach the point of internship, students who have minority clients can look to address reluctance or community barriers through interactions and questions in the therapy room. Student therapists can conduct papers on self of the therapist to address their perspective or behaviors as a therapist working with minority clients.

Secondly, future researchers could examine participants' other relationships, or specific age groups, or gender, and how this may influence or change the results. Finally, researchers could address the limitations discussed in this study, including the broad definitions for variables, and alter the questions asked to gain a clearer understanding. Refining this may influence future research in this area and add to the existing literature.

Conclusion

The current study examined the association between access and exposure on African Americans' behaviors towards utilizing mental health treatment as well as whether mental health barriers and religiosity predict whether African Americans seek mental health treatment. This study used the lens of CRT to incorporate a theoretical viewpoint that acknowledges minority mental health research that highlights biases, assumptions, and privileges.

African Americans have made great strides in addressing reluctance to mental health that include access, exposure, mental health barriers, and religiosity. The strides are in combination with the resources of insurance and gatekeepers, collaboration with churches and community leaders. Nevertheless, significant results and results that were not significant were presented.

The results from this study were consistent with previous research and identified that although access and exposure are minimal in comparison to Caucasians, African Americans who experience more access or more exposure could increase behaviors to seeking mental health treatment. Religiosity and mental health barriers were not indicative of African Americans behaviors to seek treatment.

Understanding the etiology and barriers associated with mental health in the African American can help draw conclusions in the results presented and reasons why. Based on the information provided, it is imperative to address the complications of reluctance and acknowledge the impact of stigma in order to truly address the barriers in mental health.

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APPENDIX A

Variables and Indicators

APPENDIX A

Variables and Indicators

Access to MH Treatment: Insurance (2 items)

Are you covered by insurance that covers mental health/emotional/nerve problems?	yes, no
Are you covered by government insurance that covers treatment problems with emotions, nerves, or mental health	yes, no

Exposure: Gatekeepers (3 items)

Did a spiritual advisor ever recommend that you go to a mental health specialist, clinic or program?	yes, no
Encour/pressured to see prof about ment health past yr	yes, no
Did anyone encourage you or put pressure on you to see a professional about your emotions?	yes, no

Mental Health Barriers: 6 items

Reason delay treatment – problem would get better by itself	yes, no
Reason delay treatment – problem did not bother you	yes, no
Reason delay treatment - handle problem on their own	yes, no
Reason delay treatment – think treatment did not work	yes, no
Reason delay treatment - treatment did not work before	yes, no
Reason delay treatment - Worry what	yes, no

people would think	

Behaviors to seeking mental health treatment: 14 indicators

Talked to Psychiatrist about reactions to event	yes, no
Talked to other mental health prof about reactions to event	yes, no
Talked to psychiatrist for attention difficulties	yes, no
Talked to other mental health prof for attention difficulties	yes, no
Talked to psychiatrist about fear	yes, no
Talked to other mental health professional about fear	yes, no
Talked to psychiatrist about problem	yes, no
Talked to other mental health prof about problem	yes, no
Talked to psychiatrist for worry	yes, no
Talked to other mental health professional for worry	yes, no
Talked to psychiatrist about drugs/alcohol	yes, no
Talked to other mental health prof about drugs/alcohol	yes, no
Talked to psychiatrist for separation anxiety	yes, no
Talked to other mental health prof for separation anxiety	yes, no

Control Variable: Spirituality/Religion (2 items)

How important is religion in your life? (Would you say that it is very important, fairly important, not too important or not important at all?)	very important, fairly important, not too important, not important at all
How important is spirituality in your life? (Would you say that it is very important, fairly important, not too important or not important at all?)	very important, fairly important, not too important, not important at all