Spring 5-22-2017

Utilization of Mental Health Services Amongst African-American Women

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Recommended Citation

ABSTRACT

SOCIAL WORK

BROWN, AMBER M.   B.S. KENNESAW STATE UNIVERSITY, 2012

<u>ULTILIZATION OF MENTAL HEALTH SERVICES AMONGST</u>

<u>AFRICAN-AMERICAN WOMEN</u>

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Thesis dated May 2017

This thesis examines mental health utilization amongst African-American women. The study specifically investigated the factors that may predict help seeking behaviors: depression, stigma, African acculturation, mistrust, and religious commitment. The study also examined the role demographics has on African American women utilizing mental health services. The study examined the following demographics, income, age, marital status, and education status. The sample size consisted of 40 African- American women, with ages ranging from 18 to 65. The results indicated that age and depression may impact African-American women seeking mental health services. The results showed that stigma, African acculturation, mistrust, religious commitment, income, marital status and education have no statistical significance in predicting African-American women utilizing mental health services.

UTILIZATION OF MENTAL HEALTH SERVICES AMONGST

AFRICAN-AMERICAN WOMEN

A THESIS

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF SOCIAL WORK

BY

AMBER M. BROWN

DEPARTMENT OF SOCIAL WORK

ATLANTA, GEORGIA

MAY 2017

ACKNOWLEDGEMENTS

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CHAPTER I

INTRODUCTION

The purpose of this chapter is to address the background of the challenges that African American women face when utilizing mental health services. It also serves to introduce the statement of the problem, the purpose of the study, and the research questions.

Background and Incidence of the Research Problem

This section will review the background and incidence of the problem of mental health utilization among African-American women.

Background

Underutilization of mental health services is a growing concern amongst African-Americans, particularly African-American women with untreated mental illnesses. According to Ward, Clark and Heidrich, African American women are less likely to seek mental health services in comparison to their White counterparts (Ward, Clark, & Heidrich, 2009). Not seeking treatment for mental illnesses can lead to further chronic health issues and even death. The Health and Human Services Office of Minority Health reported that African Americans are 20% more likely to face serious mental health problems than the general population (National Alliance on Mental Health, n.d). Mental health disorders that are common in the African American community are Major

Depression, Attention Deficit Hyperactivity disorder, suicide, and Posttraumatic Stress disorder (NAMI, n.d.). Additionally, African-American women are overrepresented in these populations given the reported 2:1 gender ratio of depression (Ward, Clark, Heidrich, 2009).

Stressors in the African American community can trigger mental illnesses. Violence and poverty are stressors that can trigger mental illness (NAMI, n.d). African Americans are more likely to experience poverty and be exposed to violence. Other factors that contribute to African-American women's risk of mental illness are multiple role strains, sexism, discrimination, and racism (NAMI, n.d).

Stress is a physiological response on a person's body due to needing to adapt, cope or adjust (American Psychological Association, n.d). Stress can help to keep a person alert. However, intense stress can be overwhelming on the body (American Psychological Association, n.d). Studies have found that socioeconomics and environmental stress have contributed to mental health disparities among racial groups (American Psychological Association, n.d). Health disparities that are connected to socioeconomic and environmental stress include, childhood asthma, hypertension, substance abuse, diabetes, obesity, and depressive symptoms (American Psychological Association, n.d).

Perceived discrimination is also another factor that is related to chronic stress that minority groups face. It has been known to contribute to mental health disorders amongst Asian-Americans and African-Americans (American Psychological Association, n.d).

The resiliency of the daily stress that African-American women endure can be explained by examining the Sojourner syndrome and the Superwoman Schema (SWS). African-American women were forced to take on the role of mother, nurturer, and breadwinner out economically necessity Woods-Giscombé, 2010). The development of the Strong Black Woman/Superwoman is related to the disenfranchisement of African-American men who were limited in the ability to support their families financially and emotionally (Woods-Giscombé, 2010). However, the Strong Black Woman/ Superwoman is viewed as a positive trait in the African American community that is contributed to the survival of the African American population (Woods-Giscombé, 2010). The Strong Black Woman/ Superwoman comes with unfavorable consequences. The admiration of African-American woman strength in the face of hard ship may be related to current health challenges that African-American woman currently experience today such as, cardiovascular disease, obesity, lupus, and, untreated or mistreated psychological conditions (Woods-Giscombé, 2010).

Incidence of the Research Problem

According to Mental Health America, 56% of adults with mental illness did not seek treatment in 2014. Historically, communities of color show lower rates of treatment and access to treatment (Mental Health America, n.d.). African-American women have had negative attitudes towards mental health services and may perceive utilizing mental health service as weak (Plaza, 2014). African Americans make up 13.2% of the U.S population and 16.2 % of African Americans had a diagnosable mental illness which is 6.8 million people with a diagnosable mental illness (MHA, n.d.).

Furthermore, Suicide is one of the top common killers in the U.S and the top three in young people (Scientific American, 2012). Mental illness is attributed to 90% of suicide cases in the United States (Scientific American, 2012).

Statement of the Research Problem

It is crucial that a study addresses the challenges and the needs of African-American women with regards to mental health. African-American women are increasingly becoming the primary caregivers within the household and the "gatekeepers" in the African American community. The current study will explore African American community and cultural factors such as perceived stigmas, cultural mistrust, religious commitment, acculturation, age, marital status, and education in African-American women. In order to have a better understanding of their help seeking behaviors and to better serve them.

Purpose of Study

The purpose of this study is to examine the helping seeking behaviors of African-American women utilizing mental health services. The results of this study will help inform practitioners of potential challenges and areas of concern in trying to promote help-seeking among African American women.

Research Questions and Hypotheses

This study has two research questions. The focus of this study is the main factors that impact African-American women seeking mental health services. The following are the testable questions:

RQ1. Is there a statistically significant relationship between demographic variables and utilization of mental health services amongst African American women?

H1a: A statistically significant positive correlation will exist between age and likelihood to utilize mental health services.

H1b: A statistically significant positive correlation will exist between education level and likelihood to utilize mental health.

H1c: A statically significant positive correlation will exist between income and likelihood to utilize mental health.

H1d: A statically significant positive correlation will exist between employment and likelihood to utilize mental health.

H1e: A statically significant positive correlation will exist between marital status and likelihood to utilize mental health. .

RQ2: Is there a statistically significant correlation between attitude constructs and utilization of mental health services?

H1: A statistically significant correlation does not exist between attitude factors and utilization of mental health services

Significance of the Study

This study is significant because it can be added to the larger body of knowledge of African American women and mental health services which is currently limited in research. African American women are more likely to experience negative sociopolitical experiences, including sexism, racism, and discrimination that puts them in danger of

health problems and low income jobs. All of these negative experiences are associated with the onset of mental illnesses (Schneider, Hitlan, & Radhakrishnan, 2000).

Summary Statement

As previously stated, the purpose of this chapter was to address the background, incidence, and scope of the research problem. African-American women are less likely to seek mental health services compared to their White counterparts. Not seeking treatment for mental illnesses can lead to further chronic health issues and even death. Stressors in the African American community can trigger mental illnesses. African Americans are more likely to experience poverty and be exposed to violence. Both poverty and violence can cause mental illness. Other factors that contribute to African American women's risk of mental illness are multiple role strains, sexism, discrimination, and racism. The resiliency of daily stress that African American women endure can be explain by examining the Sojourner syndrome and the Superwoman Schema (SWS). African American women were forced to take on the role of mother, nurturer, and breadwinner out of economically necessity.

The development of the Strong Black Woman/Superwoman is related to the disenfranchisement of African-American men who were limited in the ability to support their famililies financially and emotionally.

This chapter also served to introduce the statement of the research problem and the purpose of the study. African Americans make up 13.2% of the U.S population and 16.2 % of African Americans had a diagnosable mental illness; which is 6.8 million people with a diagnosable mental illness. Untreated mental illness can lead to suicide. It

is important that a study addresses the challenges and the needs of African-American

women with regards to mental health.

CHAPTER II

LITERATURE REVIEW

This chapter will review the literature, theoretical framework and Afrocentric Perspective. The purpose of this literature review is to summarize the conclusion of past research and to critically analyze completed information on related topics.   The literature review will discuss factors that have impacted African Americans utilizing mental health services. The factors of African-American women utilizing mental health in include, intentions in seeking treatment from mental health services; the impact of African Americans stigma and beliefs about mental health services, and the impact of discrimination and socio-economics when seeking mental health services.

Conceptual Definitions

This section will review the conceptual definitions used for help seeking behavior, attitude constructs to further understand help seeking behavior frameworks, assumptions, and expectations.

Help Seeking Behaviors

Help-seeking for mental health has had high levels of research and interest. Nevertheless there is currently no agreed used definition or conceptual measurement framework for help-seeking (Rickwood &Thomas, 2012).

The Oxford Dictionary defines help seeking as an "attempt to find (seek) assistance to improve a situation or problem (help)" (Rickwood &Thomas, 2012). Other help-seeking definitions include the following.

According to Unrau (2005), "help-seeking behaviors involve a request for assistance from informal supports or formalized services for the purpose of resolving emotion, behavioral, or health problems" 15:516–530.

According to Shirom (1996), "the first stage of the social support process; that is, to a person, the recipient, taking the initiative and communicating with others to request any kind of support, whether affective, evaluative, or instrumental" 26:563–576.

Rickwood and Thomas (2012), study finds evidence that an agreed definition that helps the comparable measurements of help seeking is lacking. An a agreed definition of help seeking would help to compare studies and help understand policy and practice with the goal to improve access and engagement with services for people with mental health issues (Rickwood & Thomas,2012).

Attitude Constructs

Understanding a person's attitude towards mental health services could help predict if the person seeks treatment or not. Eagly and Chaiken (1993), defined attitudes as "a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor" (p. 1). Attitude has a laid the foundation of social psychology (Schwarz & Bohner, 2001). Gordon Allport stated, "This concept is probably the most distinctive and indispensable concept in contemporary American social psychology" (Schwarz & Bohner, 2001). In order to have a better understanding of

African Americans attitudes on mental health, the study will examine various attitude constructs they can possibly predict African-American women seeking mental health services or not. The attitude constructs that will be examined include stigma, African acculturation, mistrust, and religious commitment.

Stigma

Stigma characterized as the perception of differences associated with undesirable traits (Givens, Katz, Bellamy, & Holmes, 2007). Stigma comes from societal experiences and direct individual experiences (Givens, Katz, Bellamy, & Holmes, 2007). Stigma and beliefs have a significant influence on African American seeking professional help. Research has found that African-American women historically held stigmas about mental illnesses (Ward, Clark & Heidrich, 2009).

Many African American families found that being diagnosed with a mental illness was shameful and embarrassing for the individual and for the family (Ward, Clark & Heidrich, 2009). A study by Silva de Crane and Spielberg found that African Americans thought a person being hospitalized for mental illness as different, inferior to normal people, and believed these patients should be restricted to protect society (Ward, Clark & Heidrich, 2009).

Additionally, studies shown in the 1990's found that 63% of African Americans believed that depression was a weakness and only 3% thought it was a mental illness (Ward, Clark & Heidrich, 2009). A recent study found that African-American women believed they were not vulnerable to depression (Waite & Killian, 2008). They felt that stigmas against mental illness was a significant barrier of seeking treatment (Ward, Clark

& Heidrich, 2009). Older African-American women who show symptoms of depression are less likely to seek treatment compared to African-American women under the age of 50 (Diala et al., 2000). One of the stigma's in the African American community is that mental health services over medicate their patients. Many African Americans disapprove anti-depressant medication because of the stigma of over medication (Givens, Katz, Bellamy, & Holmes, 2007).

African Americans prefer counseling instead of anti-depressant medication and counseling amongst clergy (Givens, Katz, Bellamy, & Holmes, 2007).   African Americans are concerned with being institutionalized for a reason for not seeking mental health treatment (Goalez, Alegria, Prihoda, Copeland, & Zeber, 2009).

Beliefs

According to Rokeach, belief is define as any unassuming conscious, proposition, inferred from what a person says or does (Rokeach, 1969). Many African Americans tend to believe that mental health issues are caused by loss and stress. In general, they believed worry and loss of a family member or friend can cause stress (Jimenez, Bartels, Cardenas, Daliwals, & Alegria, 2012). In comparison, Whites believed that mental illness is caused by loss of family and friends, family issues, and moving to different places (Jimenez, Bartels, Cardenas, Daliwals, & Alegria, 2012).

Since African Americans have negative views and stigmas about mental health services they rely heavily on family support and social support. African Americans view social support as protective sources against mental health problems and provide help in a time of need (Jimenez, Bartels, Cardenas, Daliwals, & Alegria, 2012). Social support is

recognized as one of the significant resources that can help individual with stressful situations (Jimenez, Bartels, Cardenas, Daliwals, & Alegria, 2012). Social support is vital to traumatic recovery (Jimenez, Bartels, Cardenas, Daliwals, & Alegria, 2012). Victims of traumatic events are less likely to experience psychological problem if they have someone they can discuss their feeling with and help them cope (Jimenez, Bartels, Cardenas, Daliwals, & Alegria, 2012). Informal support can assist their members by providing housing, physical illness, family conflict, death of a family member, and monetary issues (Jimenez, Bartels, Cardenas, Daliwals, & Alegria, 2012). There has been little study on the effect of African Americans informal support and mental health (Jimenez, Bartels, Cardenas, Daliwals, & Alegria, 2012). Dessler study found that extended kinship buffered the effect of economic strain on depressive symptoms among black men only and perceived supported guarded the effect of stress on African American women (Jimenez, Bartels, Cardenas, Daliwals, & Alegria, 2012). Findings have shown that financial assistance was the main informal support that guarded the influence of economic stress on psychological distress among African Americans (Jimenez, Bartels, Cardenas, Daliwals, & Alegria, 2012). But if African Americans social support is disrupted it could lead to mental illnesses (Jimenez, Bartels, Cardenas, Daliwals, & Alegria, 2012). However, prolonged dependence on social support can be burdensome, particularly in circumstances involving financial difficulties or severe trauma.

History of Mistreatment of Seeking MH Services

African Americans historically experienced discrimination and mistreatment when seeking mental health services. African Americans show higher rates of dissatisfaction

with services they obtain from mental health providers than Whites (Redmond et al., 2009;

Thurston & Phares, 2008). They are more likely to be mistreated by mental health services

than other races (Dancy et al., 2013). Cultural incompetence by medical providers may

affect their experiences. More than 75 % of African American patients' medical

interactions occur with someone from another race (Chen, Fyrer, Phillips, Wilson &

Patheman, 2005).

The negative experiences they endure when receiving mental health services

includes inappropriately prescribed psychotropic medication that is linked to side effects

(Jaycox et. al., 2006; Thompson et al., 2011; Ward et al., 2009), providers lacking

attentiveness and respects (Blanchard & Laurie, 2004), and breaking of confidentiality

(Draucker, 2005; Leis et al., 2011; Thompson et al., 2011). Studies show that negative

experiences have been linked to negative expectations in future use of services (Dancy et

al., 2013).

Religious Commitment

Religion plays a major role in the African American community. Religion helped

African Americans overcome a history of oppression. Pew Research Center conducted a

survey on African Americans and their commitment to religion. Pew Research Center

found that African Americans are more religious than their White's, Latino's, and Asian

counter parts (Pew Research Center, 2009). The study found that 8 out of 10 (84%)

African American reported that religion is very important in their lives compared to 56%

of the U.S population (Pew Research Center, 2009). African-American women show high

levels of religious commitment. The majority of African-American women identify as

protestant (Pew Research Center, 2009). According to the Pew survey eight out of ten African-American women (84%) say that religion is very essential to them and six out of ten (59%) say they go to church services at least once a week (Pew Research Center, 2009). No other race/ethnic group men or women show higher levels of religious commitment than African-American women (Pew Research Center, 2009).

Past research has investigated the religious effects of mental health on African Americans and depressive symptoms (Levin, Chatters, & Taylor, 2005). Studies has found there is a considerable amount of evidence that supports that religions helps prevents depressive symptoms and helps overall psychological wellbeing(Levin, Chatters,& Taylor, 2005). However, there is still little convincing indications that the effect of religion on African Americans is more noticeable (Levin, Chatters, & Taylor, 2005).

Afrocentric Ideology and Mental Health

African Americans have a unique history that have led to challenges that other ethnic groups have not experience such as, slavery, discrimination, and institutional racism (Kelly,2006). Within the 21st century, African Americans have been disproportionately represented in high pregnancy rates, single parent female headed households, alcoholism, drug addiction, academic failures, unemployment, poverty, and criminal victimization (Oliver, 1989).

To better serve African Americans who may face high rates of societal challenges social workers and other mental health practitioners have been adapting Afrocentricity as a theory of practice on African American clients. Mental health practitioners suggest that

the theory provides a better understanding of African Americans from an African

centered perspective and cultural system that gives an effective approach when

addressing racial oppression (Pellebon, 2007). Conversely, practitioners have yet to

critically analyze Afrocentricity as a source of knowledge to assist with the profession

(Pellebon, 2007). Practitioners need to examine new ideas in order to accept or reject

knowledge based on objective criteria (Pellebon, 2007).

Afrocentric Perspective Definition and Background

The African centered model was introduced in the 1970s because African-

American scholars wanted to develop a theory of social change (Bakari, 1997). The

African centered model was created in pursuit to reconstruct the social identity of African

Americans which was severed and was negatively impacted by 400 years of oppression

(Oliver, 1989). Many African Americans lost their identity and sense of purpose. The

scholars wanted to encourage African Americans to eliminate cultural crisis and

confusion by adapting traditional African values that emphasizes "mankind oneness with

nature," spirituality", and "collectivism" (Oliver, 1989, p.24).

The founding father of the Afrocentric Perspective is Molife Kete Asante. When

Asante traveled back from Africa he thought it was crazy for an African American man

to have a European name (Asante, 2003, Pellebon, 2007, p.716). He thought that primary

reason for African American's social crisis is the lack of culture (Pellebon, 2007).

The cultural crisis is influenced by Eurocentric views that have misrepresented

African history and psychologically dislocates African Americans (; Karenga, 1980;

Pellebon, 2007). Afrocentric Perspectives gives a framework in establishing an identity

for African American individuals and the community as a whole (Shriver, 2011).

Afrocentricity focuses on African Americans long history of oppression and the

principles and strength of African culture (Shriver, 2011).

There are eight principles that presents that are at the core of the perspective

(Bentley-Goodley, 2005, 1999). The principles are linear and connected. "They are

connected as part of the larger African centered paradigm, said Bent-Goodley." The

principles help individuals respect self and others and have responsibility for themselves,

peace, and interconnection between self and community (Bentley-Goodley, 2005, 1999).

The following principles are fundamental goodness: each person is fundamentally good;

self-knowledge: encourages the practitioner to begin where they are; communalism:

empathetic to independence of individuals and the community they are a part of;

interconnectedness: the collective struggle throughout the African American experience

and people are dependent of each other and considered as one; spirituality: sense of

sacredness and divine; self-reliance: members of the community are responsible to

contribute to the community and society; language and the oral tradition: language brings

people together and help people reach understanding; and combine information with

social action (Shriver, 2011; Bent-Goodley 2005,1999).

The primary goal is to release research and studies of Africans from the

hegemony of Eurocentric scholarship (Abarry, 1990). Other goals include, expose and

resist White domination; move African Americans towards their cultural center;

transform African Americans to and ideology of values, spirituality, and rituals, analyze

politics, sciences, literature, history, religion, and economics from an Afrocentric

perspective (Asante, 2005, p. 1-13). Afrocentric Perspective focuses on removing Eurocentric views which has misinformed African Americans about African history and culture (Oliver, 1989). Eurocentric views have seriously damaged and distorted the analysis of African history and have negatively impacted current African historiography (Oliver, 1989). African scholars and nationalist have been torn by the two perspectives from their own culture and the European education system (Oliver, 1989).

Furthermore, societies ideology give structure of how members of the society defines themselves and lays the foundation of spirituality and intellectual of group solidarity (Vander Zanden,1966:136). Euromericans are largely based on people of European descent who believe they are more intelligent and more beautiful than non-white groups (Jordan, 1969: Froman, 1972). All Americans who are non-White are exposed to White superiority messages and are disseminated in religious institutions, school systems, and mass media (Baldwin, 1980; Cogedell & Wilson, 1980).

African Americans lack of developing an Afrocentric ideology has led to generations of self-hatred, social, political, psychological, and economic dysfunction in the African American community (Kelly, 2006).

The African American experience in a pro-White and anti-Black society has led to mistrust in mental health services that are dominated by Eurocentric ideology (Kelly, 2006). African Americans experiences with inequality have led to psychological adjustment and particular symptom presentations (Kelly, 2006). Many African Americans experience rage and may express it to White therapist and non-white therapist who represent White cultural dominance. They may also direct anger towards family

members who may fail to support one another and are safer targets to express anger to

(Boyd-Franklin & Franklin, 1998; Kelly, 2003).

Many African Americans have deep distrust in Whites and have "health cultural

paranoia" which is a unwillingness to seek mental health treatment, and have negative

attitudes towards White therapist, and end treatment early (Whaley, 2001). African

Americans may present worldviews related to pain and oppression (Kelly, 2006). Some

may exhibit internalized racism as they become demoralized and have feelings of

nihilism or become defeated because of experiencing racism (e.g., Hines, 1998).

Therapist may interpret these views as African Americans being lazy, blaming others, or

lack motivation (Kelly, 2006).

To decrease demoralization, nihilism, and defeated attitudes in the African

American community; African Americans could enhance Afrocentric values, ideas, and

cultural ideology by creating Afrocentric intuitions that could promote self-love,

awareness of their traditional African heritage, and economic political development of

African Americans (Oliver, 1989). In order to widely practice the theory social workers

and other mental health practitioners need to critical analyze the untested perspective to

be competent in practice (Pellebon, 2007).

Theoretical Framework

African Americans' unique history of oppression and mistreatment in public

institutions has impacted their health seeking behaviors. Health Belief Model and Health

Service Utilization Model are two conceptual models that can further explain factors that

control individuals seeking health services. These two models will be explored and

critiqued in this section in terms of strengths and weaknesses.

Health Belief Model (HBM)

Health Belief Model was developed in the 1950s by Social Scientist at the U.S

Public Health Services (Boston University School of Public Health, 2016) to understand

why people tend to fail prevention strategies or screening tests (Boston University School

of Public Health, 2016). Health Belief Model health behaviors are determined by their

awareness and belief of the disease and the strategies available to reduce its existence

(Hayden, 2009).

HBM theoretical constructs. The theoretical constructs of HBM are perceived

susceptibility, perceived benefit, perceived barriers, perceived seriousness of the disease,

and self-efficacy. Perceived susceptibility is one of the most powerful constructs. It

pushes people to take healthier steps (Hayden, 2009). The bigger the risk the less likely

the person will participate in risky behaviors, for example smoking cigarettes can cause

lung cancer. Perceived benefits focus on the benefits of adopting new behaviors

(Hayden, 2009). Individuals may adopt healthier behaviors if they believe it will decrease

their risk of the disease (Hayden, 2009). For example, a person may stop smoking

cigarettes to decrease their risk of getting lung cancer.

Perceived barriers are the perceived challenges in adopting new behaviors. In

order for the individual to successfully adopt new behaviors the person has to believe

they can overcome the barriers that keep them from adopting new behaviors. (Hayden,

2009). Perceived seriousness is how the individual views the seriousness of the disease, it

is based on medical knowledge of the disease and how the disease could affect the person's life (Hayden, 2009). Self-efficacy people tend to not change if they don't believe they can change their habitual behaviors (Hayden, 2009).

The variables that may impact the four major constructs are education level, culture, past experiences, skill, and motivation (Hayden, 2009). For example, someone who was diagnosed with lung cancer and who was successfully treated would have a higher susceptibility because of past experiences and knowing the risk and harm of smoking. HBM also explains that cue of action that can also influence people change in behaviors such as, media reports, family illness, and health campaigns (Hayden, 2009).

Limitations of HBM. Firstly, it does not factor in attitudes and beliefs that can control ones acceptance of the behavior. Secondly, it does not factor in habitual behaviors that can impact the decision making process to accept change in behaviors (Boston University School of Public Health, 2016). Thirdly, HBM excludes economic and environmental factors that could stop the individual in making healthy actions (Boston University School of Public Health, 2016). Lastly, it does not state that everybody does not have equal knowledge of information (Boston University School of Public Health, 2016). HBM cues of action empower people to act which the main goal not decision is making.

African Americans and HBM. Health Belief Model is a theory that can greatly explain how African Americans beliefs could greatly impact their motivations in seeking treatment. According to Clark-Tasker (1993) many African Americans believe that mental illness is due to a failure of control to live according to God's will and an

acceptance of fate and destiny. Many African Americans believe that God can control

health and healing through faith and prayer (Swanson, 2004). Spirituality has been an

indicator for health behaviors. "God will take care of me" displays a perspective of the

African American community that no matter what they do a greater force has more

control (Jennings, 1996). Spirituality is not the only factor to consider but also culture.

Providers need to be aware and apply their knowledge of the impact of culture has on the

diagnosis and treatment of depression (Conner et al., 2010).

It is vital for clinicians to increase their knowledge about African American

beliefs in depression treatment. It could help frame treatment engagement and retention

strategies with African Americans (Conner et al., 2010). Spirituality could be a factor in

why African Americans susceptibility in mental disorders and in disease in generally low.

The Health Belief Model theorizes that perceive susceptibility and perceived severity

together contribute to perceived threat of a disease. African Americans can continue to

embrace their culture while making modifications in behavior changes a as preventative

care to help support a heathier lifestyle (Geyen, 2011). In order to change their behaviors

African Americans must perceive value in, and gain understanding in misconceptions and

behavioral threats to maintain a healthy life style (Geyen, 2011).

The Health Service Utilization Model

The Health Service Utilization model further explains why families and individual

seek health services and the factors that influence them. The Health Services Utilization

Model was created by Ronald M. Andersen to seek understanding of why families use

health services (Babitsch, Gohl, Lengerke, 2012). The conceptual model was developed

in the late1960s and focused on family's utilization of health services (Aday & Awe, 1997). The three factors that influence families and individuals to seek treatment predisposing, enabling, and needs (Babitsch, Gohl, & Lengerke, 2012). Predisposing factors include demographics such as, age, sex, education, occupation, ethnicity, social relationships and health beliefs (Babitsch, Gohl, & Lengerke, 2012). Enabling factors are individuals financial and organizations that enable health serve utilization. Need factors are how the individual look at and experience their health (Babitsch, Gohl, Lengerke, 2012).

The 1960's model focused on families' education, occupation, and ethnicity. However, it was criticized for not paying enough attention to social networks (Andersen, 1997). The model created in 1995 focused on the individual utilizing health services (Andersen, 1997). The predisposing are demographics social structure health beliefs (Babitsch, Gohl, Lengerke, 2012). The factors that determine an individual's status are community and the ability to cope with presenting problems as well as having resources to deal with the problems (Babitsch, Gohl, Lengerke, 2012). Also how healthy or unhealthy their surroundings are most likely to be. The 1995 model include the multiple influences on health use and on health status by including feedback loops that represent the common influence of results, predisposing factors, perceived needs and heath behavior (Babitsch, Gohl, Lengerke, 2012).

Strengths and HSUM. Andersen's Health Utilization Model is the most widely used framework to investigate the use of health services (Babitsch, Gohl, Lengerke, 2012). The model is strongly developed and its system variables have changed focus

throughout the decades (Babitsch, Gohl, & Lengerke, 2012). In the 1970s HSUM focused

on environments external to the health care system and health outcomes. In the 1980s it

focused on feedback loops. The 1990s concentrated on psychosocial influences beyond

belief issues. The 2000s the model explained genetic susceptibility as an individual

factor. Most recently the model covers the broad spectrum of individual characteristics

that affects utilization (Babitsch, Gohl, & Lengerke, 2012).

      HSUM Limitations. The Andersen's Health Utilization Model however has

limitation is inconsistency in findings and the considerable differences in predisposing,

enabling, and need factors. The studies included, age gender, education, and ethnicity as

predisposing factors (Babitsch, Gohl, Lengerke, 2012). Income, having a source of care,

and health insurance were used as enabling factors and perceived health and wide variety

of disease were used as need factors (Babitsch, Gohl, Lengerke, 2012).

      Health Utilization Model & African Americans. The Health Utilization model

could further explain the barriers that face African Americans in utilization health

services. Predisposing factors, enabling factors, need factors can affect African

Americans seeking treatment. The African Americans population is considered a high

needs population with high levels of mental health disorders and in need of treatment

(Office of the Surgeon General, CMHS, NIMH, 2001). They are 3.5 time more likely to

be homeless than Whites (Office of the Surgeon General, CMHS, NIMH, 2001). African

Americans have higher rates of disease, disability and mortality than their white

counterparts (Office of the Surgeon General, CMHS, NIMH, 2001). They also have

higher levels of psychological distress than their white counterparts and lower rates of well-being than Whites.

African Americans history of racism and discrimination has greatly affected their utilization of health services (Bradley, 2002). Racism has been in research as central societal force that adversely affects the health of racial and ethnic populations (Cooper, 1993). "Racism is defined as ideology of superiority that ranks various groups and negative beliefs and attitudes of one group can negatively affect the groups overcomes in societal institutions" (Williams, 1997). Racism on the level of societal institutions could shape social economic opportunity and mobility (Williams, 1997). In the face discrimination and racism African Americans have made education and income strides. However, African Americans are over-represented in vulnerable populations in comparison to their White counter-parts. African Americans are more likely to become homeless, incarcerated, face violence and be placed in foster care (Office of the Surgeon General (US); Center for Mental Health Services (US); National Institute of Mental Health (US), 2001).

They may also lack health insurance (Office of the Surgeon General, NIMH, 2001). One-fourth of African Americans are uninsured (Office of the Surgeon General, NIMH, 2001). African Americans are more likely to work marginal jobs that do not offer insurance care (Office of the Surgeon General, NIMH, 2001). Insurance coverage is one of the major determinants in one seeking treatment care (Office of the Surgeon General, Center for Mental Health Services, NIMH, 2001). African Americans having insurance coverage is the biggest determinants care (Office of the Surgeon General, Center for

Mental Health Services, NIMH, 2001). Financial barriers pose as the major determinant in African Americans seeking treatment.

Summary Statement

This chapter discussed several conceptual definitions including help seeking behaviors, attitude constructs, stigmas, and beliefs. This section also included evaluation of literature. The study found that stigma and beliefs have a significant influence on African American seeking professional help. For example, studies found that many African American families thought that being diagnosed with a mental illness was shameful and embarrassing for the individual and for the family.

African Americans negative experience with mental health have an impact them seeking services. African Americans are more likely to be mistreated by mental health services than any other races. Studies have shown that negative experiences have been linked to negative expectations in future use of services. African Americans negative experience with mental services and practitioners had led them to find other alternatives. African Americans prefer counseling amongst clergy instead of anti-depressant medication.

According to the Pew survey eight out of ten African American women (84%) say that religion is very essential to them, and six out of ten (59%) say they go to church services at least once a week. No other race/ethnic group men or women show higher levels of religious commitment than African American women.

The section further explained how African ideology can assist mental health practitioner in working with African Americans. It provides a better understanding of

African Americans from an African centered perspective and cultural system that gives

an effective approach when addressing racial oppression. Afrocentricity focuses on

African Americans long history of oppression and the principles and strength of African

culture. To decrease demoralization, nihilism, and defeated attitudes in the African

American community, African American could enhance Afrocentric values, ideas, and

cultural ideology by creating Afrocentric intuitions that could promote self-love,

awareness of their traditional African heritage, and economic political development of

African Americans.

The chapter concluded with a discussion of the theoretical framework. Health

Belief Model health behaviors are determined by people awareness and belief of the

disease and the strategies available to reduce its existence. Health Belief Model is a

theory that can greatly explain how African Americans beliefs could greatly impact their

motivations in seeking treatment. The Health Service Utilization model explains why

families and individual seek health services and the factors that influence them.

CHAPTER III

METHODOLOGY

This chapter methodology refers to the practices and procedures for conducting this study. The section includes a review of the research questions and hypotheses. Additionally, information on the design of the study, the sampling methods; data collection methods, and data analysis methods are included.

Review of Hypotheses and Research Questions

RQ1. Is there a statistically significant relationship between demographic variables and utilization of mental health services among African-American women?

H1a: A statistically significant positive correlation will exist between age and likelihood to utilize mental health services.

H1b: A statistically significant positive correlation will exist between education level and likelihood to utilize mental health services.

H1c: A statically significant positive correlation will exist between income and likelihood to utilize mental health services

H1d: A statically significant positive correlation will exist between employment and likelihood to utilize mental health services.

H1e: A statically significant relationship will exist between marital status and likelihood of utilizing mental health services among African-American women.

RQ2: Is there a statistically significant correlation between attitude constructs and utilization of mental health services?

H1: A statistically significant correlation does not exist between attitude factors and utilization of mental health services.

Study Design

The study used a quantitative, cross sectional research design. Quantitative research gathers numerical data through statistical analysis in an attempt to determine a connection between the independent and dependent variables (Shuttleworth, 2008). The cross sectional component of the study design, addresses the collection of the data at one definite point in time (Shuttleworth, 2010).

The study sampling method was a convenient, non-probability random sampling technique. Non-probability is a method that selects participants in a technique that does not give everyone in the population the same chances of being selected (Abu-Bader, 2011). A convenience sampling method of non-probability sampling is when participants are chosen because they are available to the researcher (Abu-Bader, 2011). The study was data collected in the summer of 2016.

African American women have a limited amount of studies on utilizing mental health services. An exploratory design identified barriers that impacts African-American women seeking treatment from mental health services.

The exploratory design gave insight on how mental health practitioners can develop mental health services that are designed to fit the needs of African-American women. The study relied on nonprobability sampling and data to investigate in one point in time. For participants' convenience the data was collected by online surveying. The online survey was inexpensive and was sent out to a large group of African-American women (Rubin & Babbie, 2013). Additionally, the online surveying software Qualtrics processed the participant's information that eliminated manual data entry (Rubin & Babbie, 2013).

Recruitment

The study successfully recruited 52 participants and collected the information needed. The study used word of mouth to family and friends to successfully recruit African-American women. It recruited African-American women over the age of 18. The study was interested in participant's beliefs and past experiences in seeking treatment from mental health services. Each participant was sent an email invitation on social media outlets and emails to take the online survey. The snowballing technique was used in recruitment. For example, each participant was ask to invite others to participate in the survey.

The data was collected in the Atlanta metropolitan area. According to the 2000-2010 U.S Census, the Atlanta metropolitan area has the largest African American population in the state of Georgia. The Atlanta Metropolitan area includes, Clayton County, Cobb County, DeKalb County, Fulton County, Gwinnett County, Henry County,

Rockdale County, and Roswell County. The 2010 U.S Census, an estimate of 1.7 million

African Americans called the Atlanta Metropolitan area home.

Fulton County leads the 10 counties in having the largest populations of African

Americans with 405,575 African American residents, DeKalb is second with 375,725,

then Cobb with 171,774, and Clayton County follows after Cobb with 171,480.

Questionnaire

The research was based of the conceptual framework Andersen Healthcare

Utilization Model. The Health Belief Model will be within the framework to structure

the variables. The Andersen Healthcare Utilization Model is highly flexible, which

allowed the researcher to choose the independent variable from the hypothesis. The

conceptual framework is the most widely used framework to predict healthcare utilization

since it was created over 40 years ago. Andersen's model was created to research the

inequality of access to health services in the United States (Willis, Glaser & Price, 2010).

It explained some parts of society such as, minorities who lived urban and rural

communities who receive less health care than the rest of the population (Willis, Glaser

& Price, 2010).

Andersen current model looks at the individual decisions in accessing services

that are based on the individual's positions in society and health services availability

(Willis, Glaser & Price, 2010). Andersen model explores the hypotheses concerned with

social inequalities (Willis, Glaser & Price, 2010).

The healthcare utilization model has three sets of predictive factors: predisposing,

enabling and need factors. The predisposing are characteristics that will predict if the

person will use health services (Willis, Glaser & Price, 2010). The second factor is the

enabling the availability of services and the perceived actual need to use health services

(Willis, Glaser & Price, 2010).

Furthermore, in Andersen's original 1968 model, ethnicity was one of the

predisposing variables (Willis, Glaser & Price, 2010). The model explained that ethnicity

was a factor in a family's position in society and could predict the utilization of health

services (Willis, Glaser & Price, 2010).

The Health Belief model was developed in the 1950's by U.S department of

Public Health to explain why medical screening for tuberculosis was not being used

(Hayden, 2009). The Health Belief model has five set of factors: perceived seriousness,

is the person's belief of the seriousness of the disease (Hayden, 2009). The perceived

susceptibility is the perceived risk that could decrease the dangerous behaviors. Perceived

benefit is the person's opinion on the value of changing the dangerous behavior into a

healthier behavior (Hayden, 2009). Perceive barrier is what are the persons own

challenges in adopting new behaviors (Hayden, 2009). Another component to HBM is

cues of action which are events, people and things that help a person change their

behavior (Hayden, 2009). Self-Efficacy is the person's belief in do something to change

their behaviors (Hayden, 2009).

The questionnaire included questions that aligned with Health Belief Model five

factors: 1.perceived seriousness, "psychological problems, like many things, tend to work

out by themselves". 2. Perceived susceptibility "keeping one's mind on a job is a good

solution for avoiding personal worries and concerns". 3. Perceived benefit "If good

friends asked my advice about a psychological problem, I might recommend that they see a professional." 4. Perceived barrier "Important people in my life would think less of me if they were to find out that I was experiencing psychological problems." 5. Cues of Action "If I believed I were having a mental breakdown, my first inclination would be to get professional attention."

The questionnaire examined the participant's demographics and social status to perceived barriers. The study also observed the participant's self-reliance to examine the participant's cues of action and self-reliance. The study's questionnaire chose questions that were the most relevant to the Health Belief Model five factors.

Measures and Instruments

The following variables were tested: demographics, social status, mistrust, stigma, cultural acculturation, religious, and self-reliance. Participants were measured by a self-report cross sectional. The questionnaire was based on commonly used instruments including, the Cultural Mistrust Inventory, Perceived Devaluations, National Survey of American Life Battery, and Measurement of Acculturation Strategies for People of African Descent (MASPAD) Inventory of Attitudes Toward Seeking Mental Health Services. The variables were guided by the Andersen Health Utilization model predictive factors.

Inventory of Attitudes Toward Seeking Mental Health Services. To examine participants help-seeking attitude the study used the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS). The inventory asked questions that include

(e.g., "I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.").

The participants gave responses using a 6-point continuum ranging from "strongly disagree (1) to "strongly agree. High scores indicated a positive attitude toward seeking professional services for psychological problems. The original inventory scale consisted 24 items but due to convenience and time constraints of the participants taking the full questionnaire packet the study truncated the IASMHS to 9 questions. The shortening of the inventory may have lowered the overall validity and reliability of the questionnaire. The 9 items were selected to observe the respondents help seeking behavior.

Cultural Mistrust Inventory. Cultural mistrust was measured by the Cultural Mistrust Inventory. The CMI is the most frequently used instrument to measure mistrust (Smith, 2009). The original version is a 48 item inventory that measures the extent African American mistrust of White. It measure four areas of mistrust: education training, ("Blacks should teach their children not to trust White teachers"), interpersonal relationship (e.g., "Blacks should be suspicious of a White person who tries to be friendly"), business (e.g., "A Black person can usually trust his or her White co-worker"), and politics and law (e.g., "Blacks have often been deceived by White politicians") (Smith, 2009).

The original inventory consists of 48 items but for participants and researcher convenience it was narrowed down to a 5 item inventory. The researcher selected these 5 items based on the items that were the most relevant to mental health services. Participants rated their opinion on a six-point Likert scale ranging from strongly disagree

(1) to strongly agree (6). To acquire the subscale score, points for each items are added, negatively keyed items are scored in the reverse direction.

The higher scores indicate an inclination of distrust of Whites. The original inventory scale consisted 48 items but due to convenience and time constraints of the participants taking the full questionnaire packet the study truncated the Cultural Mistrust Inventory to 5 questions the of shortening of the inventory may have lowered the overall validity and reliability of the questionnaire.

The Perceived Devaluation Discrimination Scale. The Perceived Devaluation Discrimination Scale is how participants rated their attitudes on how other people view psychiatric patients in a statement (Smith, 2009). For example, "most people would not hire a former mental patient to take care of their children, even if he or she had been well for some time (Smith, 2009). The participant's rated on a 6 point Likert scale from strongly disagree to strongly agree. The Perceived Devaluation Discrimination scale is unidimensional with greater scores expressing a higher perceived stigma (Smith, 2009).

The original inventory scale consisted 12 items but due to convenience and time constraints of the participants taking the full questionnaire packet the study truncated the Perceived Devaluation Discrimination Scale to 6 items. The shortening of the inventory may have lowered the overall validity and reliability of the questionnaire. These 6 items were selected based on how strongly respondents how strongly they believe in society stigmas about mental health patients. Questions included "Most people would willingly accept a former mental patient as a close friend" and "Most people believe that entering a mental hospital is a sign of personal failure."

Measurement of Acculturation Strategies for People of African Descent. To measure how strongly participants identify with the African American culture the Measurement of Acculturation Strategies for People of African Descent (MASPAD) was used. The MASPD evaluate the universal processes of acculturation, and is formulated specifically for people of color. It evaluates two components of the African American culture traditionalist and assimilationist (Smith, 2009). Participants rate their response on a 6 point continuum (1) strongly disagree and (6) strongly agree. Higher scores reflect a person being or a traditionalist. High scores on traditionalist mean more of a connection to the African culture, ("I was socialized to treat my elders with respect") (Smith, 2009).

The original inventory scale consisted 48 items but due to convenience and time constraints of the participants taking the full questionnaire packet the study truncated the IASMHS to 3 items. The shortening of the inventory may have lowered the overall validity and reliability of the questionnaire.

Religious Commitment Inventory. Religion is a trusted institution in the African American community and many African Americans depend on churches for emotional support and hope. The study utilized the Religious Commitment Inventory that measured the participants' commitment to their religious values, beliefs, practice their religion daily (Smith, 2009). Participants response was measured by a five-point Likert scale from not at all true of (1) to totally true of me (5). For example, Religious beliefs influence all my dealings in life" (Smith, 2009).

The original inventory scale consisted 10 items but due to convenience and time constraints of the participants taking the full questionnaire packet the study truncated the

IASMHS to 3 items. The shortening of the inventory may have lowered the overall validity and reliability of the questionnaire. These 3 items were based on how proud and connected the respondents were African ancestry. For example, "I take a great deal of pride in being a person of African ancestry" and "I do not feel connected to my African heritage."

   The National Survey of American Life Battery. To understand participants perceived and actual needs for mental health services and who they rely on for emotional support. A section of questions was based off of the National Survey of American Life Battery which is a well-known longitudinal study of African Americans attitudes and behaviors (Smith, 2009). Participants were asked to rate the likely-hood of using informal and formal resources to help with problems of mental health concerns (Smith, 2009). The participant's rated1 through 12 of what resources they are more likely to use. The options are psychologist, social worker, counselor, any other mental health professional, psychiatrist, general practitioner or family doctor any other medical doctor: a religious or spiritual advisor like a minister, priest, or rabbi, or any other healer; a spouse, partner, or family member; or self-reliance, attend to concern yourself, or wait for improvement. Participants ranked who they seek out from 1 to 12 to indicate who their primary source for support is.

   In addition to the measurements the questionnaire asked participants if they had a history of mental illness or utilizing mental health services. "Have you ever used mental health services such as, a therapist, counselor, psychologist, social worker, or other mental health professional for help?" The questionnaire participants are currently

depressive symptoms. "Feeling down, depressed, or hopeless" to examine if the

participants are aware of symptoms of depression.

Summary Statement

This methodology section discussed the used practices and procedures to conduct

and replicate this study. The study used a quantitative, cross sectional research design.

The study recruited 40 participants in Atlanta, Ga area by word of mouth. The

participants were 18 to 63 years' old. Each participant was sent an email invitation on

social media outlets and emails to take the online survey. The snowballing technique was

used in recruitment.

This section included a review of the research questions and hypotheses, the

discussion of the used study design, the sampling methods, the data collection methods,

and the data analysis methods Participants were measured by a self-report cross sectional.

The questionnaire was based on commonly used instruments including, the Cultural

Mistrust Inventory, Perceived Devaluations, National Survey of American Life Battery,

and Measurement of Acculturation Strategies for People of African Descent (MASPAD)

Inventory of Attitudes Toward Seeking Mental Health Services.

CHAPTER IV

RESULTS

The results section will include a statistical description of the sample size. The Pearson's Product-Moment Correlation Coefficient, ANOVA, Simple Linear Regression to determine if there is a relationship between independent variables and the dependent variable. The section will answer the study's questions and test the hypothesis to accept or reject the null hypothesis.

Overview of Sample

The sample consisted of 40 African-American women (see Table 1 for a breakdown of demographics). The total numbers of respondents were 52 however, the researcher deleted 12 respondents who did not finish the questionnaire or identify themselves as non-African American. Six (15.0%) of the respondents were between the ages of 18-22. Eighteen (45.0%) of the respondents were between the ages of 25-34. Nine (22.5%) of the respondents were between the ages of 35- 54, and seven (17.5%) of the respondents were between the ages of 55-75 or older.

The majority the respondents were single, never married, n=24 (60%). Nine (22.5%) of respondents were married or in a domestic partnership. Seven (17.5%) of respondents were separated, divorced, or widowed.

Additionally, the majority (75%) of the respondents were employed for wages (n=30). One (2.5%) of respondents was self-employed. Seven (17.5%) of the respondents were students. Two (5.0%) of the respondents were retired.

The majority of the respondents' income were 50,000-74, 999 n=14 (30.5%); ten (25.0%) of respondents made $29,999 and under; twelve (30%) respondents made $30,000 to $49,999; four (10%) of respondents made $75, 000- $150,000 and over.

The majority of the respondents had a Bachelor's degree (n=19, 47.5%). Thirteen (32.5%) of respondents who had a graduate degree or Doctorate. Eight (20%) respondents who had up through an associate degree level of schooling.

Overall the majority of the respondents age ranged from 25-34, never married, with a Bachelor's degree, employed for wages, and had an annual income between $50,000-74,999. Table 1 displays these results.

Table 1

Descriptive Statistics for Study Sample

Variable	Attributes	n	%
Marital Status	Never Married	24	60
	Married	9	22.5
	Separated, Divorced, Widowed	7	17.5
Highest Level of Education	Up to Associate's Degree	8	20.0
	Bachelor's Degree	19	47.5
	Graduate or Doctorate Degree	13	32.5
Employment	Student	7	17.5
	Employed for wages	30	75.0
	Self employed	1	2.5
	Retired	2	5.0
Ages	18-24	6	15.0
	25-34	18	45.0
	35-54	9	22.5
	55 or older	7	17.5
Annual Income	$29,999 and under	10	25.0
	$30,000-$49,999	12	30.0
	$50,000-$74,999	14	30.5
	$75,000 or over	4	10

Reliability and Validity

The reliability analysis examines if the items on the scales are correlated. To measure the reliability of each scale, the study used the Cronbach Alpha. The Cronbach Alpha helps measure the strength and consistency of each scale. The study included the following scales Cultural Mistrust Inventory, Perceived Devaluation Discrimination Scale, Acculturation Strategies for People of African Descent (MASPAD), the National Survey of American Life Battery, Religious Commitment inventory, and Attitudes toward Seeking Mental Health Services (IASMHS) were all comprised in the questionnaire to measure the significance between African American women attitude constructs and utilizing mental health services.

The Depression Scale consisted of three items with a low alpha score of -.431. In order to strengthen the alpha score, the researcher eliminated item 8 and the alpha score risen to a .207. The trimming of the items may have a significant effect on the validity of the scales. The Inventory of Attitudes toward Seeking Mental Health Services scale consisted of 10 items with an alpha score of .764. The Perceived Devaluation Discrimination Scale consisted of 7 items with a low alpha score of .114. In order to strengthen the alpha score, the researcher eliminated item 25 and the alpha score risen to a .362. The Cultural Mistrust Scale consisted of 5 items with a moderate alpha score of .749. In order to strengthen the alpha score, the researcher eliminated item and the alpha score risen to a .780. The Religious Commitment Inventory consisted of three items with a strong alpha score of .899. The African Acculturation Scale consisted of three items with a low alpha score of .201. In order to strengthen the alpha score, the research

eliminated item 36 and the alpha score risen to .278. The National Survey of American

Life Battery consisted of 4 items with a low alpha score of .347.

Descriptive Statistics for Scales

The questionnaire consisted of a total of 44 questions. The first section contained

8 items that examined the respondents past experiences of utilizing mental health services

and mental health symptoms. The first 6 questions asked the respondents about their past

usage of mental health services. The questions included: "have you ever used mental

health services such as, a therapist, counselor, psychologist, social worker, or other

mental health professional for help?" Respondents were given the choice of answering

"yes or no". Fifty-two percent of the respondents answered yes. The past usage of mental

health services also included the following question: "how likely will you seek mental

health services this year?" The respondents answer choices included: "extremely likely,

moderately likely, moderately unlikely, and extremely unlikely" Thirty-nine percent of

the respondents answered "extremely unlikely." Section one of the questionnaire

included the National Survey of American Life Battery that asked the participants to

report any symptoms of depression. The three choices included: "Feeling down,

"depressed" and hopeless" respondent answering choices includes: "Not at all, "several

days", "more than half the days" and "nearly every day" Over 60% of the respondents

answered "Not at all".

Section two contained the Inventory of Attitudes toward Seeking Mental Health

Services (IASMHS) the scale examined the respondents helping seeking attitudes, it

consisted of 9 items with the highest score being 54 and lowest score being 9.

Respondents choices include the following: "strongly disagree", "disagree", "somewhat disagree", "somewhat agree", "agree", and "strongly agree".   The section items included, "I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems." Over 39% of the respondents answered "agreed".

Section three included the Perceived Devaluation Discrimination Scale that examined the respondent's attitudes and stigma's about mental health it consisted of 6 items that sought to evaluate respondent's attitudes toward befriending a former mental health patient. Respondent choices include the following: "strongly disagree", "disagree", "somewhat disagree", "somewhat agree", "agree", and "strongly agree". Roughly 38% of the respondents answered "somewhat agreed" in regards to accepting a former mental patient as a close friend.

Section four contain the Cultural Mistrust Inventory that measured the extent African American mistrust of Whites it consisted of 5 questions with the potential highest score being 30 and the lowest score being 5. The respondents answered with strongly disagree, disagree, somewhat disagree, somewhat agree, agree, strongly agree. The questions included, "It is best for blacks to be on their guard when among whites" 33.33% the majority of respondents "Somewhat agreed" that blacks should be on guard amongst whites.

Section five contained the Religious Commitment Inventory that measured the respondent's religious commitment; it consisted of three questions with the potential highest score being 18 and the lowest score being 3. Over 30% of the respondents strongly agreed that religion is important to them.

Section six contained the Measurement of Acculturation Strategies for People of African Descent. It measured how strongly the respondents identify with the African culture that consisted three of items with the potential highest score being 18 and the lowest score being 3. Some question included: "I take a great deal of pride in being a person of African ancestry (African, African American, Black Cuban, Black Brazilian, Trinidadian, Jamaican, etc.)" Over 67% of the respondents strongly agreed that they take a great deal of pride in being a person of African ancestry.

Table 2

Descriptive Statistics for Scale Variables

Scale	# of Items	Mean	SD	a
Depression Scale	2	4.125	2.109	.207
IASMHS Scale	10	4.813	6.964	.764
PDD Scale	5	3.380	3.303	.362
Cult Mistrust Scale	4	3.225	4.131	.780
Religious Comm	3	2.867	4.465	.899
Acculturation	2	5.150	1.856	.278
Mental Health Utiliz	4	2.875	3.146	.347

(*N=40*)

Data Evaluation

The study used a statistical analysis software SPSS that provides statistical procedures that aided the researcher in gaining an accurate understanding of the study. The data was cleaned using data cleaning techniques. The cases that were incomplete were removed.

Results

The research topic investigated African-American women utilization of mental health services. RQ1. Is there a statistically significant correlation between demographics variables and utilization of mental health services?

Research Question One

Is there a statistically significant relationship between demographic variables and utilization of mental health services among African-American women?

Bivariate analysis. Bivariate analysis is one of the simplest forms of statistical analysis it is used to find if there is a relationship between two sets of values. A One-way ANOVA was used to determine if there were statistically significance in demographics that included, age, education, employment status, and income. ANOVA test the differences between groups with a continuous dependent variable (Abu-Bader, 2010). One-way ANOVA is a continuation of the independent t-test (Abu-Bader, 2010). It helps researchers study the mean differences among two or more independent variables (Abu-Bader, 2010). The study consisted of 40 respondents. The dependent variable was how likely respondents were to seek mental health services in 2016. It is a continuous variable measured at the interval level. The data was analyzed using the SPSS program. The study

met all the expectations of the hypothesis testing. Tables 2 through 5 revealed that there

was a significance of (p<.052) age but not in, employment status (p=.572), education

level (p<.426) or income (p<.303).

One-way analysis of variance. The first independent variable age was measured

at the nominal level and consisted of four groups 18-24, 25-34, 35-54,55-74 or older.

The results of the One way ANOVA for age found a significance of (p<.052).

Table 3

One-Way ANOVA Summary Table –Age

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	7.427	3	2.476	2.825	.052
Within Groups	31.548	37	.876		
Total	38.975	40			

The second independent variable was employment status. It was measured at the

nominal level and consisted of four groups student, employed by wages, self-employed,

and retired. Employment status results found an insignificant value of (p=.572).

Table 4

One-Way ANOVA Summary Table-Employment

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	2.080	3	.693	.676	.572
Within Groups	36.895	37	1.025		
Total	38.975	40			

The third independent variable was education level. It was measured at the nominal level and consisted of three groups: high school diploma/GED, Some college credits with no degree, Technical/Vocational training, Associates degree. The second group consisted of respondents with Bachelor's degree. The third group was respondents with Graduate level degrees. The third variable level of education results found an insignificant value of (p<.426).

Table 5

One-Way ANOVA Summary Table –Education

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1.758	2	.879	.874	.426
Within Groups	37.217	38	1.006		
Total	38.975	40			

The fourth independent variable was income status. It was measured at the nominal level and consisted of four groups: $29,999 or under, $30,000-49,999, $50,000-$74,999, $75,000-150,000 or over. Income status results found an insignificant value of $(p<.303)$.

Table 6

One-Way ANOVA Summary Table –Income

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	3.701	3	1.234	1.259	.303
Within Groups	35.274	37	.980		
Total	38.975	40			

Research Question Two

Is there a statistically significant correlation between attitudes constructs and utilization of mental health services? The study used Pearson's Product-Moment Correlation Coefficient to examine if attitude constructs that included African Acculturation, mistrust, depression, attitudes stigma, and religion have relationship in respondents seeking mental health services. The researcher used Pearson's Product-Moment Correlation Coefficient to test the strength of the relationship (Bader, 2010). The objective of the Pearson's product-moment correlation coefficient is to observe if an increase in the independent variable leads to an increase or decrease in the dependent variable (Bader, 2010).

The study's independent variable is how likely the respondents will seek mental health services in 2016. The dependent variables are African Acculturation, mistrust, depression, attitudes, stigma, and religion The tables 2 through 5 revealed below that there was a significance of (p<.023) depression but there was no significance in African acculturation (p<.838), mistrust (p<.893), attitudes (p<.264), stigma (p<.894), religion (p<.816).

Pearson's Product-Moment Correlation Coefficient. Pearson's Product-Moment Correlation Coefficient was used to examine if African Acculturation, mistrust, depression, attitudes stigma, and religion have a relationship in respondents seeking mental health services; the researcher used Pearson's Product-Moment Correlation Coefficient to test the strength of the relationship (Bader, 2010). The objective of the Pearson's product-moment correlation coefficient is to observe if an increase in the

independent variable leads to an increase or decrease in the dependent variable (Bader, 2010). The study's independent variable is how likely the respondents will seek mental health services in 2016. The dependent variables are African Acculturation, mistrust, depression, attitudes, stigma, and religion.

The researcher studied the strength of African Acculturation and how likely will the respondents seek mental health services from the Correlations table, it can be seen that the correlation coefficient (r) equals -.033, indicating an insignificant relationship, as surmised earlier. $p < .838$ and indicates that the coefficient is significantly different from 0.

Second, the researcher examined the strength of mistrust and how likely the respondents seek mental health services from the Correlation table. Based upon the correlation coefficient (r) equals - .002, indicates a weak relationship, as surmised earlier. $p < .893$ indicates that the coefficient is not significantly different.

Third, the researcher examined the strength of depression and how likely the respondents seek mental health services from the Correlation table. Based upon the correlation coefficient (r) equals, indicates a significant relationship, as surmised earlier $p < 023.$indicates that the coefficient is not significantly different.

Fourth, the researcher examined the strength of attitude and how likely the respondents seek mental health services from Correlation table. Based upon the correlation coefficient equals .111, indicates an insignificant relationship, as inferred earlier $p < .497$ indicates that the coefficient is not significantly different. The researcher studied the strength of stigma and how likely the respondents seek mental health

services from the Correlation table. Based upon the correlation coefficient (r) equals -

.064, indicates an insignificant relationship, as presumed earlier .p< .694 and indicates

that the coefficient is not significantly different.

Lastly, the researcher examined the strength of religion and how likely the

respondents seek mental health services from the Correlation table. Based upon the

correlation coefficient (r) equals .094, indicates an insignificant relationship as

concluded earlier .p<.94 indicates that the coefficient is not significantly different.

Table 7

Correlations Statistics of Study Sample

	Utilization	Acculturation	Mistrust	Depression	Attitudes	Stigma	Religion
Acculturation	-						
Mistrust	-.002	-					
Depression	.139	-.283	-				
Attitudes	.111	-.171	.011	-			
Stigma	-.064	-.197	-.057	.029	-		
Religion	.562	.264	.30	.50	-.212	-	
Utilization	.838	-.022	.360	-.181	.022	.038	-

*p<.10; **p<.05; ***p<.01

Multivariate analysis. The study found a relationship between age and

depression with regards to respondents seeking mental health services. To analyze if age

and depression together are predictors of participants seeking mental health services the

study used a multivariate a technique. Multivariate analysis is an extension from

ANOVA and one of the most used techniques within the social sciences (Abu Bader,

2012). Multivariate analysis looks at the mean difference between levels of one or more

independent variables on two or more dependent variables.

The Multiple Regression technique is used to examine age and depression. The

multiple regression analysis is an advance statistical technique that is widely used in the

social sciences (Bader, 2010). The purpose of a multiple regression is to examine the

impact of multiple independent variables with one dependent variable (Bader, 2010). The

results of the multiple regression analysis revealed that age and depression appears as

significant predictors of respondents likeliness in seeking mental health services

(F=4.224, p=.0022). With a beta of .26 (t=1.604, p=.117), age and depression accounted

for 19% of the variance in respondents likeliness in seeking mental health services in

2016. However, the two variables age and depression together do not have significance with

β=.26 .117.

Table 8

Regression Analysis of Age and Depression Scale

	Utilization of Mental Health Services	
	B*(SE)*	β
Age	.270 (.05)	-.03
Depression	.424(.04)	-.29
R	.431	
R²	.186	
F	4.224(*df*=2)	

Summary Statement

The results section discussed the statistical description of the sample size. The study found that the   majority of the respondents age ranged from 25-34, never married, with a Bachelor's degree, employed for wages, and had an annual income between $50,000-74,999.The tested the validity and reliability of the instruments utilized in the questionnaire by using the Cronbach alpha test. The study found Depression scale, Perceived Devaluation Discrimination Scale, African Acculturation scale, National Survey of American Life Battery had low alpha scores. The Inventory of Attitudes toward Seeking Mental Health Services scale, Cultural Mistrust Scale, and Religious Commitment Inventory had a high to moderate alpha score.

The questionnaire consisted of a total of 44 questions and 6 sections. The sections included the National Survey of American Life Battery that asked the participants to report any symptoms of depression, Attitudes toward Seeking Mental Health Services Scale, Perceived Devaluation Discrimination Scale, Cultural Mistrust Inventory, Religious Commitment Inventory, and Measurement of Acculturation Strategies for People of African Descent. The study used the software SPSS to analyze the results of research questions one and two.

The study used A One-way ANOVA was used to determine if there were statistically significance in demographics that included, age, education, employment status, and income. Age had a significant relationship with respondents seeking mental health services, education, employment status, and income did not have a significant

relationship. To test question two the study used Pearson's Product-Moment Correlation Coefficient to examine if African Acculturation, mistrust, depression, attitudes stigma, and religion have a relationship in respondents seeking mental health services. The results found that depression had a strong relationship with respondents seeking mental health services; African Acculturation, mistrust, attitudes, stigma, and religious commitment did not have strong relationship with respondents seeking mental health services. To examine if age and depression together are predictors of participants seeking mental health services the study used a multivariate a technique. The results of the multiple regression analysis revealed that age and depression appears as significant predictors of respondent's likeliness in seeking mental health services. However, the two variables age and depression together do not have significance.

CHAPTER V

DISCUSSION

This chapter will state the summary of the findings, discussion of the findings, and the significance of the study as it relates to the field of social work. Additionally, the limitations and recommendations for future research will be discussed.

Summary of the Study Findings

The study sought to examine two research hypotheses. The first research question asked the following: Is there a statistically significant relationship between demographic variables and utilization of mental health services among African-American women? The second research question asked: Is there a statistically significant correlation between attitude constructs and utilization of mental health services? The results of the study were as follows: Age and depression showed the most significance in predicting the likelihood of African-American women seeking mental health services. Other demographic variables that included marital status, education level, employment, and income did not have a statistically significance in African-American women seeking mental services. Similarly, attitude constructs African acculturation, mistrust, attitude, stigma, and religion showed no statistically significance in African-American women seeking mental health services. Age and depression predicted the likelihood of African-American women in seeking mental health service thus, the null hypothesis rejected.

Discussion of the Findings

The study results suggest that age and depression may have an impact on the likely hood of African-American women seeking mental health services. Other studies agree that age has an impact on an individuals' help seeking attitude. According to the Substance Abuse and Mental Health Administration in 2014, women who were 18 years and older were more likely than men to have a serious mental illness in the past year (5% vs. 3.1%). Other studies reported that mental health improves with age (SAMSHA, 2014). In 2008, SAMSHA broke down the percentage of age groups seeking mental health services. SAMSHA finding showed that 40.4 % of 18 to 25 year old sought out mental health services, 62.2 % of 26 to 49 year old's sought out mental health services and 70.9% of 50 and older sought out mental health services (National Institute of Mental Health, n.d).

Furthermore, depression affects more than 6.5 million Americans who are 65 years or older. Depression left untreated can lead to cognitive decline and suicide (SAMSHA, 2014). Studies also found the seeking treatment has risen from 2005 to 2008. Adults seeking treatment in 2005 to 2008 has increased from 65% to 71.0% (SAMSHA, 2014). Furthermore, women who are diagnosed with depression are more likely to seek treatment than men (74.2% vs. 65%) (SAMSHA, 2014).

Significance of the Study

The study made contributions to mental health via giving further information on African-American women seeking treatment; this population is viewed as a need population among mental health practitioners. The study also included the Afrocentric

Perspective that is rarely used in research. The majority of researcher uses the

Eurocentric perspective. Afrocentric Perspective goals include, expose and resist white

domination; move African Americans towards their cultural center; transform African

Americans to and ideology of values, spirituality, and rituals, analyze politics, sciences,

literature, history, religion, and economics from an Afrocentric perspective (Asante,2005,

pp1-13). The study contributed to understanding African-American women's needs in the

community as well as their dual roles in their households.

Limitations and Recommendations

The study limitations include small sample size, non-random sampling technique,

scales, and time sensitivity. The study used a total of 40 participants it is suggested to use

65% of the population the researcher is studying. The study used non-random sample

technique that may have led to bias. The majority of the participants were in the age

ranged from 25 to 34 years old, never married, with a Bachelor's degree, employed for

wages, and had an annual income between $50,000-74,999. The researcher collected the

data from May 2016 to October 2016 which may have contributed to low respondents

and bias. Due to time constraints and deadlines the researcher only had 5 months to

collect date. Additionally, most of the respondents were young adults who annual

incomes were between $50,000 to-74,999 and with a Bachelor's degree. The study may

have bias because it lacked respondents from diverse backgrounds such as, African-

American women who are unemployed or who dropped out of high school.   The scales

that the researcher has used may have measured another construct other than the ones the

study tested. The shortening of the scales for respondent's convenience also caused a

lower reliability and validity. The recommendations for future studies on African-American women seeking mental health services are to increase the sample size, conduct a random sampling technique, and have 6 months to a year to gather data; usage of a lower number variables and restrain from shortening scale items. Lastly, increase the sample population and increase the validity and reliability of the testing.

Conclusion and Summary

In conclusion, this chapter focused on several different sections including the summary of the findings, discussion of the findings, the significance of the study as it relates to the area of social work, the limitations and recommendations for future studies, and the human subject issues. It was the study intention to examine the helping seeking behaviors of African-American women utilizing mental health services. The study focus on factors that may impact African-American women seeking services that included demographics and attitude constructs. A One-way ANOVA was used to determine if there were statistically significance in demographics that included, age, education, employment status, and income.

The study found that age show the strongest statistically significant relationship with the respondents seeking mental health services. The Pearson's Product-Moment Correlation Coefficient was used to examine if African Acculturation, mistrust, depression, attitudes stigma, and religion have a relationship in respondents seeking mental health services. The study found that there was a statistically significant relationship between depression and African American seeking mental health services. Researcher believes that other attitude constructs and demographics play a role in

African- American women seeking services. However, a small sample size, bias, scales, and shortening of scales may have significantly impacted the results. Further researcher on the topic is highly suggested. African-American women are a high needs populations. They are more likely to experience poverty and be exposed to violence and are forced to take on the role of mother, nurturer, and breadwinner. In order for mental health practitioners to assist African-Americans women they need to be more cultural competency. African Americans have a history of being discriminated against and mistreated in mental institutions.

A way mental health practitioners and institutions can incorporate Afrocentricity as a theory of practice on African American clients. It's a theory provides a better understanding of African Americans from an African centered perspective and cultural system that gives an effective approach when addressing racial oppression. The study suggests that continued research on the role of age and depression has on African-American women and how to successfully implement Afrocentricity in treating African-American women.

REFERENCES

Abu-Bader.H.Soleman. (2010). *Advanced & Multivariate Statistical Methods for Social Science Research with a Complete SPSS Guide.* Chicago, Illinois: Lyceum Books, Inc.

Aday, L. Awe, W. (1997*). Handbook of Health Behavior Research I. Personal and Social Determinants.* New York, NY: Prelum Press.

Andersen, M., R. (1995). Revisiting the Behavioral Model and Access to Medicare: Does it. Matter? *Journal of Health and Social Behavior. Volume 36. March 1-10.* Retrieved from

http://mph.ufl.edu/files/2012/01/session6april2RevisitingBehavioralModel.pdf

Babitsch, B., Gohl, D., & von Lengerke, T. (2012). Re-revisiting Andersen's Behavioral Model of Health Services Use: a systematic review of studies from 1998–2011. *GMS Psycho-Social-Medicine, Volume 9*. Retrieved from

http://doi.org/10.3205/psm000089

Bakari, S. (1997). *Epistemology from an Afrocentric Perspective. Enhancing Black Students 'Consciousness through an Afrocentric Way of Knowing. Different Perspectives on Majority Rules. People of Color in a Predominantly White Institutions.* Nebraska, University Nebraska Press. Retrieved from

http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1019&context=pocpwi
2

Boston University School of Public Health. (2016). *Behavioral Health Models.*
Retrieved from http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/SB721-
Models/SB721-Models2.html.

Bradley, E. H., McGraw, S. A., Curry, L., Buckser, A., King, K. L., Kasl, S. V., &
Andersen, R. (2002). Expanding the Andersen Model: The Role of Psychosocial
Factors in Long-Term Care Use. *Health Services Research, 37*(5), 1221–124.
Retrieved from http://doi.org/10.1111/1475-6773.01053

Conner, K. O., Lee, B., Mayers, V., Robinson, D., Reynolds, C. F., Albert, S., & Brown,
C. (2010). Attitudes and beliefs about mental health among African American
older adults suffering from depression. *Journal of Aging Studies, 24*(4), 266–277.
http://doi.org/10.1016/j.jaging.2010.05.007

Cook, B. L., Doksum, T., Chen, C., Carle, A., & Alegría, M. (2013). The role of provider
supply and organization in reducing racial/ethnic disparities in mental health care
in the U.S. *Social Science & Medicine (1982), 84,* 102–109. Retrieved from
http://doi.org/10.1016/j.socscimed.2013.02.006

Dashiel J. Geyen. (2002). Behavioral Changes for African Americans To Improve
Health, Embrace Culture, and Minimize Disparities. *ECI Interdisciplinary
Journal for Legal and Social Policy, Volume 2.* Article 2.

Levin, Jeff, Chatters. M. L, Taylor. R.L. (2005). Religion, Health and Medicine in
    African Americans: Implications for Physicians. Volume. 97, No. 2. Retrieved
    from http://www.baylorisr.org/wp-content/uploads/levin_african.pdf

Lincoln, K. D., Chatters, L. M., & Taylor, R. J. (2005). Social Support, Traumatic
    Events, and Depressive Symptoms among African Americans. *Journal of
    Marriage and the Family, 67*(3), 754–766.

Giordano, C. Elliott, K. King, R. Sribney, W. Deeb-Sossa, S. Sala, M. Aguilar-Gaxiola,
    S. (2009). *Building Partnerships: Conversation with African American and
    Mental Health Needs and Community Strength*. Retrieved from
    http://www.ucdmc.ucdavis.edu/

Givens, J. L., Katz, I. R., Bellamy, S., & Holmes, W. C. (2007). Stigma and the
    Acceptability of Depression Treatments among African Americans and Whites.
    Journal of General Internal Medicine, 22(9), 1292–1297.
    http://doi.org/10.1007/s11606-007-0276-3

Gonzalez, J. M., Alegría, M., Prihoda, T. J., Copeland, L. A., & Zeber, J. E. (2011). How
    the relationship of attitudes toward mental health treatment and service use differs
    by age, gender, ethnicity/race and education. Social Psychiatry and Psychiatric
    Epidemiology, 46(1), 45–57. http://doi.org/10.1007/s00127-009-0168-4

Hammond, W. P. (2010). Psychosocial Correlates of Medical Mistrust among African
    American Men. *American Journal of Community Psychology, 45*(1-2), 87–106.
    http://doi.org/10.1007/s10464-009-9280-6

Hankerson, S. H., Watson, K. T., Lukachko, A., Fullilove, M. T., & Weissman, M. (2013). Ministers' Perceptions of Church-Based Programs to Provide Depression Care for African Americans. *Journal of Urban Health : Bulletin of the New York Academy of Medicine, 90*(4), 685–698. http://doi.org/10.1007/s11524-013-9794-y

Hayden, J. (2009). *Introduction to Health Behavior Theory.* Boston, MA: Jones & Bartlett Learning, LLC.

Jimenez, D. E., Bartels, S. J., Cardenas, V., Daliwal, S. S., & Alegría, M. (2012). Cultural Beliefs and Mental Health Treatment Preferences of Ethnically Diverse Older Adult Consumers in Primary Care. *The American Journal of Geriatric Psychiatry, 20*(6), 533–542. http://doi.org/10.1097/JGP.0b013e318227f876

Kelly, S. (2006). *Cognitive-behavioral therapy with African Americans*. Retrieved from http://gsappweb.rutgers.edu/cstudents/readings/Summer/Kelly_Diversity/Kelly%202002006%20CBT%20with%20African%20Americans.pdf

National Institute of Mental Health. *Use of Mental Health Services and Treatment among Adults*. Retrieved from https://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-adults.shtml

National Alliance on Mental Illness. (n.d) *African Americans Mental Health.* Retrieved from http://www.nami.org/Find-Support/Diverse-Communities/African-Americans

Ngui, E. M., Khasakhala, L., Ndetei, D., & Roberts, L. W. (2010). Mental disorders, health inequalities and ethics: A global perspective. *International Review of*

Psychiatry (Abingdon, England), 22(3), 235–244.

http://doi.org/10.3109/09540261.2010.485273

Oliver, W. (1989). Black Males and Social Problems: Prevention through Afrocentric

Socialization. *Journal of Black Studies, 20*; 15. DOI:

10.1177/002193478902000102. Retrieved from

http://scounsel.tripod.com/sitebuildercontent/sitebuilderfiles/oliver_afrosocializati

on.pdf

Office of the Surgeon General (US); Center for Mental Health Services (US); National

Institute of Mental Health (US). Mental Health: Culture, Race, and Ethnicity: A

Supplement to Mental Health: A Report of the Surgeon General. Rockville (MD):

Substance Abuse and Mental Health Services Administration (US); 2001 Aug.

Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK44244/

Pellebon, D. A. (2007). *Advances in Social Work*. Retrieved from

https://journals.iupui.edu/index.php/advancesinsocialwork/article/view/139/140

Plaza, R. (2014). Links between Disorder, Mistrust and Mental Health Service Utilization

in African-American Communities. Retrieved from http://silbermanvoices.com/

Pew Research Center (2009). *A Religious Portrait of African-Americans.* Retrieved from

http://www.pewforum.org/2009/01/30/a-religious-portrait-of-african-americans/

Romano, V. Scott, Imani. (2014). Using Health Belief Model to Reduce Obesity

Amongst African American and Hispanic Populations. *Procedia Social and*

Behavioral Sciences. Volume 159, 23 December 2014, Pages 707–711. Retrieved

from http://www.sciencedirect.com/science/article/pii/S1877042814065872

Rubin. & Babbie, E. (2013). Essential Research Methods for Social Work. Belmont, CA:

    Brooks/Cole Empowerment Series.

Schiele, H. J. (1990). Organizational Theory from an Afrocentric Perspective. *Journal of*

    Black Studies Vol.21 No.2, December 1990, 145-161. State University of New

    York at Stony Brook. Retrieved from

    http://jbs.sagepub.com/content/21/2/145.extract

Schriver, J. M. (2011). *Human Behavior and the Social Environment* (5th ed.). Boston,

    MA: Pearson.

Smith, M, A. (2009) *The culture connection: testing a model of African American*

    attitudes toward mental health service utilization. University of Kentucky

    Doctoral Dissertations Retrieved from

    http://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1722&context=gradschoo

    l_diss

Substance Abuse and Mental Health Association. *Topics*. Retrieved from

    http://www.samhsa.gov/specific-populations/age-gender-based

Suite, D. H., La Bril, R., Primm, A., & Harrison-Ross, P. (2007). Beyond misdiagnosis,

    misunderstanding and mistrust: relevance of the historical perspective in the

    medical and mental health treatment of people of color. *Journal of the National*

    Medical Association, 99(8), 879–885.

Swanson,L. Crowther, M. LGreen, L. T, Armstrong. (1997). African Americans, faith

    and health disparities. Retrieved from

    http://www.rcgd.isr.umich.edu/prba/perspectives/springsummer2004/swanson.pdf

Thompson, R., Dancy, B. L., Wiley, T. R. A., Najdowski, C. J., Perry, S. P., Wallis,

    Knafl, K. (2013). African American Families' Expectations and Intentions for

    Mental Health Services. *Administration and Policy in Mental Health, 40*(5), 371–

    383. Retrieved from http://doi.org/10.1007/s10488-012-0429-5

Ward, E. C., & Heidrich, S. M. (2009). *African American Women's Beliefs about Mental*

    Illness, Stigma, and Preferred Coping Behaviors. Research in Nursing & Health,

    32(5), 480–492. Retrieved from http://doi.org/10.1002/nur.20344

Willis, R. Glaser, K. Price, D. (2010). *Applying the Andersen behavioral model to*

    informal support among Britain's ethnic minorities. Institute of Gerontology,

    King's College London. Retrieved from

    http://www.britishgerontology.org/DB/gr-editions-2/generations-review/applying-

    the- andersen-behavioural-model-to-informa.html