A study of the perceptions of depression, spirituality, and treatment among African Americans

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This study examines the perceptions of depression, spirituality, treatment modalities including both traditional and nontraditional treatments among African Americans. Two hundred and four respondents were selected for this study utilizing non-probability convenience sampling. The survey participants were composed of African Americans who attended a large metropolitan Atlanta Christian church and self-reported no history of being clinically/medically diagnosed with depression. The survey questionnaire consisted of a demographic information section and questions that defined the four variables, depression, spirituality, traditional treatment and nontraditional treatment. The responses were measured in a four point Likert scale. Phi (Φ) test statistic was used to test the strength of the relationships among the variables. The chi-square test statistic used to test statistical significance of the results. The findings of the study indicated that eighty percent of the participants did not report depressive symptoms. Women reported more depressive symptoms than men. Spirituality was
reported as being important in managing depression. However, the majority of the survey respondents would not seek or use traditional or nontraditional treatments for depression. There was a significant statistical difference in the report of depressive symptoms between men and women. Women reported more depressive symptoms. There were no significant differences in the responses among African American men and women in regards to spirituality, traditional and non-traditional treatments.
A STUDY OF THE PERCEPTIONS OF DEPRESSION, SPIRITUALITY, AND TREATMENT AMONG AFRICAN AMERICANS

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

BY
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CHAPTER I
INTRODUCTION

Each year in the United States, depression affects an estimated 17 million people at an approximate annual direct and indirect cost of $53 billion. One in four women is likely to experience an episode of severe depression in her lifetime, with a 10–20% lifetime prevalence, compared to 5–10% for men. The average age a first depressive episode occurs is in the mid-20s, although the disorder strikes all age groups indiscriminately, from children to the elderly (Gotlib & Hammen, 2009).

Depression ranks as one of the major health crises of today and is among the most prevalent of all psychiatric disorders. The rates of depression are so high that the World Health Organization (WHO) Global Disease Study (2005) ranked depression as the single most burdensome disease in the world in terms of total disability among people in mid-life. Depression will be the second largest killer after heart disease in 2020 (Murray & Lopez, 1996).

Kessler and Chui (2005), in their study, estimate that about twenty percent of the American population, primarily women will experience a clinically significant episode of depression at some point in their lives. This is a significant increase over rates reported two decades ago and earlier. Over ten million Americans will be afflicted by one of the
various types if depression at some point in their lives. Further more fifteen percent of depressed people will commit suicide (NIMH, 2005).

In the 18-39 and 40-59 age groups, those with income below the federal poverty level had higher rates of depression than those with higher income. Among persons 12-17 and 60 years of age and older, rates of depression did not vary significantly by poverty status (Crosby & Mollock, 2007).

An epidemiological study conducted by Gotlib and Hammen (2009) reported that approximately seven percent of women will suffer from a major depressive disorder during some point in their lives. Three percent of American men will suffer from a major depressive disorder. Approximately four percent of children will be diagnosed with depression at some point in their life. Combining and totaling these statistics averages to approximately five percent of the population will be diagnosed with depression each year.

According to Gotlib and Hammen (2009), depression is a mental illness that can disturb the person that is affected by it both, mentally and physically. Nearly fifteen percent of individuals exhibiting depression in one year have a co-occurring disorder, compared with three percent of the general population. Depression is correlated with diseases such as diabetes, coronary artery disease, chronic arthritis, and stroke. Treating an individual with multiple co-morbid disorders can be costly, and challenging when coordinating care among diverse medical providers (Egede, 2005).

People with depression are nearly twice as likely as individuals without depression to smoke. In any given month, people with depression consume
approximately forty-four percent of cigarettes smoked nationwide, based on a nationally representative sample (Nicholson, Kuper, & Hemingway, 2006).

There are significant economic costs to depression. In a recent analysis of depression in the workplace, Kessler and colleagues (2006) estimated that the annual salary-equivalent costs of depression-related lost of productivity in the United States exceeds $36 billion.

In a study conducted on the effects of depression in the workplace (Kessler, Akiskal, Ames, Birnbaum, Greenburg & Hirschfield, 2006), found that depression caused a loss of $44 billion each year in both presenteeism (the act of remaining on the job but not being as productive because of illness or stress) and absenteeism. This figure does not take into account the impact of depression on factors such as the performance of co-workers, turnover, and industrial accidents so it is likely to be an underestimate of the actual costs.

In addition, to these findings concerning the impact of depression on health and workplace productivity, there is mounting evidence that depression adversely affects the quality of interpersonal relationships and in particular, relationships with spouses, and children. The rate of divorce is higher among depressed than among non-depressed individuals (Wade & Cairney, 2000). Furthermore the children of depressed parents have themselves been found to be at elevated risks for psychopathology which includes attention deficit disorder, anxiety and impulse control disorders (Hammen, Shih, Altman & Brennen, 2004).

Studies on depression have indicated a sexual bias. Studies have consistently shown that women are considerable more likely to acquire the disease of depression than
men. African American women were more likely to be depressed than white women and Hispanic women. In addition, women of color as compared to white women, often have additional stress and risk factors, which increase their risk for depression. Women are more likely than men to seek help for this illness. The gender difference in depression has been found for decades in studies using a variety of measures of depression and across many different cultures (Gotlib & Hammen, 2009).

Most studies indicate that the causes of depression in women and men are not different but that women suffer these causes more than men do. There is substantial evidence that social conditions tied to women’s lesser power and status is social society compared to men contribute to the higher rates of depression in women (Beauboef-Lafontant, 2007).

Converging evidence suggests that women disadvantaged by poverty or racial and ethnic minority status are more likely to experience depression than the rest of the US populations. At the same time they are less likely to seek or remain in treatment for depression in traditional mental health settings (Grote, Zuckoff, Bledsoe, & Geibel, 2007).

However, studies now indicate that men may present differently in terms of symptoms for depression. In the beginning if the twenty first century the National Institute on Mental Health (NIMH, 2000) initiated investigation into depression in African American women but recent studies indicate an increase in depression and suicide in African American men (Ward & Collins, 2010).

Eighty percent of depressed people are not currently receiving any treatment. Finding and obtaining effective medical treatment for depression, can be extremely
difficult, particularly for racial and ethnic minorities. The disparities in care for racial and ethnic minority groups pose a significant public health crisis because racial minorities are continually underserved by mental health providers (Maass-Robinson, 2006).

Fifty-four percent of people believe depression is a personal weakness. This is particularly true for African Americans. The African American community has historically sought treatment less often, and diseases usually have progressed significantly when they finally seek treatment. At this progressed stage there are fewer treatment options available to them (Maass-Robinson, 2009).

According to the Report of the Surgeon General (2001), only sixteen percent of African Americans with a diagnosable mood disorder or depression seek care from a mental health specialist, and only approximately thirty percent seek care from any medical provider.

Depression and other diseases of the brain have always carried a social and cultural stigma especially for African Americans. These conditions continue to be seen as sign of weakness rather than an illness. It has been historically difficult for African Americans to trust health care providers, due to in many cases, inept and inappropriate care. With depression the African American community is especially skeptical of treatment. There is fear, shame and embarrassment of being and ignorance of what being depressed means (Bell, 2004).

Research shows that Black Americans are more likely than whites to suffer severe, untreated and disabling depression. Researchers at the Harvard School of Public Health (2004), analyzed data on 6,082 people who took part in a national survey conducted between 2001 and 2003. They found that 17.9 percent of white Americans had
depression at some point in their lives, compared with 10.4 percent of blacks of African
descent and 12.9 percent of blacks of West Indian or Caribbean descent.

In this same study (Harvard, 2004), rates of depression reported twelve months
prior to the survey were slightly greater than seven percent for Caribbean blacks; seven
percent for whites; and approximately percent for blacks of African descent. Among
those who reported depression at some point in their lives, rates of depression reported
twelve months prior to the survey were fifty-seven percent for blacks of African descent;
fifty-six percent for Caribbean blacks; and thirty-nine percent for whites.

Fewer than half of the African Americans (forty-five percent) and less than a
quarter (24.3 percent) of the Caribbean blacks who met the criteria (for depression)
received any form of major depressive disorder therapy," the study authors wrote. About
fifty-seven percent of white Americans with major depression received treatment.

In the March issue of the Archives of General Psychiatry (2004), the researchers
reported that relative to whites, both black groups were more likely to rate their major
depressive disorder as 'severe' or 'very severe' and more disabling.

Statement of the Problem

African Americans are the second largest minority population in the U.S., making
up approximately 13.4% or roughly 40.7 million people (U.S. Census Bureau, 2001).
Unfortunately, an estimated 7.5 million African Americans have undiagnosed mental
disorders. When this number is included with diagnosed African American the number
may be high as 15 million, which represents almost thirty-seven percent of the African
American population (Davis, 2005).
A major finding of Surgeon General’s report on mental health (2001) is that racial and ethnic group minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity. There are striking disparities among African Americans when it comes to the availability of mental health services and the underlying knowledge base. They are less likely to receive needed care. When they do receive care it is more likely to be poor quality (Carrington, 2006).

The estimated number of cases of depression in the African American community is inconclusive and often contradictory. Few studies have attempted to obtain prevalence reports for this population (Gotlib & Hammen, 2009). Although there is some debate about the relative prevalence rates of depression in African Americans compared to Whites, there is little debate among investigators that there is a shortage of research data on depression in African Americans. Lack of adequate and sufficient research on African Americans contributes to the problems of misdiagnoses, under diagnosed, and under treatment for depression in African Americans, (Carrington, 2006).

According to the literature women are twice as likely as men to develop a diagnosable depression disorder (Beauboef-Lafontant, 2007). African American women were more likely to be depressed than white women and Hispanic women. Available published statistics by Boykin (1994) suggest that African-American women report more depressive symptoms than African-American men or European-American women or men, and that these women have a depression rate twice that of European-American women.

In the past African American women have been the focal point of studies on depression but recent studies and demographic data indicate changes in depression
among men especially African American men (NIMH, 2008). Many African American men are burdened with depression due to unique stressors including racism and discrimination, educational attainment, occupational status, income and poverty. The prevalence of depression and poor mental health outcomes for African American men is quickly approaching a public health crisis, as evidenced by their increasing rate of suicide. Ninety-two percent of depressed African-American males do not seek treatment.

Unfortunately, research focusing on addressing the needs of African American men is scarce (Ward & Collins, 2010). The research literature on depression in Black women is inconclusive with some studies reporting a higher number of symptoms in White females and other studies reporting a greater prevalence of symptoms in African American women (Wilhelm, et al., 2002). Part of this confusion is because past published clinical research on depression in African-American women has been scarce. This scarcity is, in part, due to the fact that African-Americans may not seek treatment for their depression, may be misdiagnosed, or may withdraw from treatment because their ethnic, cultural, and/or gender needs have not been met (Carrington, 2006).

Furthermore, African-Americans may be reluctant to participate in research studies because they are uncertain as to how research data will be disseminated or are afraid that data will be misinterpreted. In addition, there are few available culturally competent researchers who are knowledgeable regarding the phenomenon of depression in African-American women. Subsequently, African-Americans may not be available to participate in depression research studies (Carrington, 2006).
Purpose of the Study

The purpose of this study is to examine the perceptions of depression, spirituality, and treatment both traditional and nontraditional modalities for depression among a non-medically diagnosed sample of adult African Americans who attend a large metropolitan church in Atlanta, Georgia.

Research Questions

The research questions of this study were as follows:

1. Do African American women and men report symptoms of their depression?
2. Do African American women and men rely on spiritual practices when depressed?
3. Do African American women and men use traditional forms of treatment when depressed?
4. Do African American women and men use nontraditional forms of treatment when depressed?

Hypotheses

The null hypotheses for the study were as follows:

1. There is no statistically significant difference between the number of African American women and men who report symptoms of their depression.
2. There is no statistically significant difference between the number of African American women and men who rely on spiritual practices when depressed.

3. There is no statistically significant difference between the number of African American women and men who use traditional forms of treatment when depressed.

4. There is no statistically significant difference between the number of African American women and men who use nontraditional forms of treatment when depressed.

Significance of the Study

Although there is some debate about the relative prevalence rates of depression in African Americans compared to Whites, there is little debate among investigators that there is a shortage of research data on depression in African Americans Carrington, 2006). This study examines the perceptions of depression, spirituality, traditional and nontraditional treatment modalities among African American population which is an understudied and underserved population in mental health. The study included both African American men and women respondents and provides a snap shot of a self-reported prevalence rate of depression for the sample of adult African Americans. The results of this study will impact diagnosing and treating depression, guiding policy or serving as a basis for programs that will improve the quality of life in the African American community.
CHAPTER II
REVIEW OF LITERATURE

The purpose of presenting this review of the literature was to lay a scholarly foundation to establish need for the study. This chapter is a review of the current literature on depression and African Americans. The review covers a historical perspective of African Americans. Depression, spirituality, traditional and non-traditional treatments are reviewed and related to the special needs of African Americans. Finally a conceptual framework for this study is presented.

African Americans

African Americans occupy a unique place in the history of America and in contemporary national life. The legacy of slavery and discrimination continues to influence their social and economic standing. The mental health of African Americans can be appreciated only within this wider context. African Americans are resilient and form social ties and bonds that have enabled many to overcome adversity and to maintain a high degree of mental health (Bell, 2004).

Approximately twelve percent of people in the United States or 34 million people identify themselves as African American (US Census Bureau 2001). However, this figure may be lower than actual number because African Americans are overrepresented among people who are hard to reach through the census, such as those who are homeless or
incarcerated. According to William & Jackson (2000), census takers often miss younger and middle age African American men because they are overrepresented in these vulnerable populations and because they often refuse to participate in the census. The African American population is increasing in diversity as greater number of immigrants arrives from Africa and the Caribbean. Indeed, six percent of all blacks in the United States today are foreign born. Most of them come from the Caribbean, especially the Dominican Republic, Haiti, and Jamaica (U.S. Census, 2001).

Historical Context

The overwhelming majority of today’s African American population traces its ancestry to the slave trade from Africa. Over a period of 200 years, millions of Africans are estimated to have been kidnapped or purchased and then brought to the Western hemisphere. Ships delivered them to the Colonies and later to the United States. Legally, they were considered chattel or the personal property of their owners (Curtin, 1969).

By the early 1800s, most Northern States had taken steps to end slavery, where it played only a limited economic role, but slavery continued in the South until the Emancipation Proclamation in 1863 and passage of the thirteenth amendment to the U.S. Constitution in 1865 (Healey, 1995).

The fourteenth amendment (1868) extended citizenship to African Americans and forbade the States from taking away civil rights; the fifteenth amendment (1870) prohibited disenfranchisement on the basis of race. However, these advances did not eliminate the subjugation of African Americans. The right to vote, supposedly assured by the 15th amendment, was systematically denied through poll taxes, literacy tests,
grandfather clauses, and other exclusionary practices. Racial segregation prevailed. Many Southern State governments passed laws that became known as Jim Crow laws or 'black codes,' which reinforced informal customs that separated the races in public places, and perpetuated an inferior status of African Americans (Latif & Latif, 1994).

The economy of the South remained heavily agricultural, most people were poor, exploited and consigned to the bottom of the economic ladder, and most African Americans worked as sharecroppers. They rented land and paid for it by forfeiting most, if not all of their harvested crops. Some worked as agricultural laborers and were paid rock bottom wages. With very low, irregular incomes and little opportunity for betterment, African Americans continued to live in poverty. They were kept dependent and uneducated, with limited opportunities (Thernstrom & Thernstrom, 1997).

As late as 1910, eighty nine percent of all blacks lived in legalized subservience and deep poverty in the rural south. When World War I interrupted the supply of cheap labor provided by European immigrants, African Americans began to migrate to the industrialized cities in the North. As Southern agriculture became mechanized, and the need for industrial workers in the Midwestern and Northeastern States increased, African Americans moved north in even greater numbers. Following World War II blacks began to migrate to selected urban centers in the West, mostly in California.

Segregation continued until the early 1950s, then in 1954, in Brown v. Board of Education, the Supreme Court declared racially segregated education unconstitutional. In the 1960s, a protest movement arose that was led by Reverend Dr. Martin Luther King, Jr. The activists confronted and sought to overturn segregationist practices, often at considerable peril. New legislation followed. The Civil Rights Act of 1964 prohibited
both segregation in public accommodations and discrimination in education and employment. The Voting Rights Act passed in 1965, suspended the use of voter qualification tests (Latif & Latif, 1994).

The African American experience in the United States has many episodes of subjugation and displacement. Yet, it is also characterized by extraordinary individual and collective strengths that have enabled many African Americans to survive and do well, often against enormous odds. Through mutual affiliation, loyalty and resourcefulness, African Americans have developed adaptive beliefs, traditions, and practices. Today, their levels of religious commitment are striking: Almost eighty-five percent of African Americans describe themselves as 'fairly religious' or 'very religious' (Taylor & Chatters, 1991.)

For African Americans a successful coping strategy is the tradition of turning for aid to significant others in the community, especially family, friends, neighbors, voluntary associations and religious figures. This strategy has evolved from the historical African American experience of having to rely on each other, often for their very survival (Hatchet & Jackson, 1993).

African Americans have also developed a capacity to downplay stereotypical negative judgments about their behavior and to rely on the beliefs and behavior of other African Americans as a frame of reference. For this reason, at least in part, most African Americans do not suffer from low self-esteem (Crocker & Major, 1989).

African Americans have a collective identity and perceive themselves as having a significant sphere of collectively defined interests. Such psychological and social
frameworks have enabled many African Americans to overcome and sustain a high degree of mental health (Gray-Little & Hafdahl, 2000).

What it means to be an African American, belonging to a certain race, cannot be taken for granted. Racial classification based on genetic origins is of questionable scientific legitimacy and of limited utility as a basis for understanding complex social phenomena (Yee, Fairchild, Weizmann & Wyatt, 1993).

Still, the category “African American” provides a basis for social classification. African Americans are recognized by their physical features and are treated accordingly. Many African Americans identify as African American; they share a social identity and outlook (Cooper & Denner, 1998).

Scholars have defined and measured aspects of the sense of self, the regard others hold for African Americans, what African Americans believe about the regard others hold for them and beliefs about the role and status of African Americans (Sellers, et al., 1998).

Current Status

In spite of the Great migration to the North, a large African American population remained in the South, and in recent years, a significant return migration has taken place. Today, fifty-three percent of all Blacks live in the South. Another thirty-seven percent live in the Northeast and Midwest, mostly in metropolitan areas. About ten percent of all blacks live in the West (U.S. Census bureau, 2001).
Many African Americans still live in segregated neighborhoods. Poor African Americans tend to live among other African Americans who are poor. Poor neighborhoods have few resources, a disadvantage reflected in high unemployment rates, homelessness, crime, and substance abuse (Wilson, 1987).

Children and youth in these environments are often exposed to violence, and suffer from abuse and neglect. They encounter too few opportunities for safe organized recreation and other constructive outlets. Personal vulnerabilities are exacerbated by problems at the community level, beyond the sphere of individual control (National Research Council, 1993).

Not all African Americans communities are distressed. Like other well functioning communities, stronger African American communities (both rich and poor) possess cohesion and informal mechanisms of social control, sometimes called collective efficacy. Evidence indicates that collective efficacy can counteract the effects of disabling social and economic conditions. Collective efficacy also forms the foundation for community-building (Bell & Fink, 2000).

In 2000, there were approximately, 9 million African American families in the United States. On average African American families are larger than white families. African Americans have shown an upward trend in educational attainment throughout the latter half of the twentieth century. By 1997, there was no longer a gap in high school graduation rates between African Americans and whites. The number of African Americans enrolled in college in 1998 was 50 percent higher than the number enrolled a decade earlier. By 2000, 79 percent of African Americans age 25 and over had earned at
least a high school diploma and seventeen percent has attained a bachelor’s or graduate degree (DHHS, 2006).

When considered in aggregate, African Americans are relatively poor. In 1999, about twenty percent of African American families had incomes below the poverty line (17,029 for a family of 4 in 1999) and only ten percent of all U.S. families did (U.S. Census, 2001c). The difference in poverty rates has shrunk over the past decade, however, and the socioeconomic distribution of African Americans has become increasingly complex (DHHS, 2006).

At one end of the income spectrum, the official poverty rate may understate the true extent of African American poverty. African Americans are more likely than whites to live in severe poverty, with incomes at or below the 50 percent poverty threshold. The African American rate of severe poverty is more than three times the white rate. There is considerable turnover in poverty population (Hudson & Spencer, 2006). Most of the white poor move out of poverty over time but are replaced by others. African Americans move in and out of poverty, but their periods of poverty tend to last longer, making African Americans more likely than whites to suffer long term poverty (DHHS, 2006).

African American families fall well below white families on important aggregate financial resources; total wealth, net worth, the value of assets minus liabilities is a useful indicator. The median net worth of whites is about ten times that of blacks (U.S. Census Bureau, 2001). This wide disparity reflects limited African American family assets, lower rates home of ownership, limited savings, and few investments.

Since most African Americans are descendents of deeply impoverished rural agricultural workers, many contemporary African Americans can expect to borrow only
modest sums from relatives and can expect only small inheritances. Most African
American have little financial cushion to absorb the impact of the social, legal, or health
related adversity that often accompanies mental illness (O'Hare, 1996).

While many African American live in poverty many others have joined the
middle class. Between 1997, African Americans benefited from a thirty one percent boost
in their real median household income, a rate that contrasts with an eighteen percent
increase for whites. Nearly a quarter of all African Americans had incomes greater than
$50, 000 in 1997, and the median income of African Americans living in married couple
households was eighty-seven percent that of comparable whites. Almost thirty-two
percent of African Americans lived in the suburbs (Thernstrom & Thernstrom 1997).

Thus in socioeconomic terms, the African American population has become
polarized. May African Americans are very poor and sometimes suffer an added burden
from living in impoverished communities. African Americans poor and non-poor alike
possess relatively few financial assets. However, a large and increasing number of
African Americans have more than expected have taken up well earned positions in the
middle class (O'Hare, 1996).

The black middle class has grown substantially. In 2000, 47% of African
Americans owned their homes. The poverty rate among African Americans has decreased
from 26.5% in 1998 to 24.7% in 2004. African Americans are the second largest
consumer group in America with a combined buying power of over $892 billion
currently and likely over $1.1 trillion by 2012. In 2002 African American owned
businesses accounted for 1.2 million of the US's 23 million businesses (DLBLS, 2006).
African Americans still operate out of prejudice and ignorance when it comes to disease of the brain or "mental illness". The African American community has historically sought treatment less often, has been much sicker when finally are forced to seek care, and has had fewer treatment options when health care is needed (Maass-Robinson, 2004).

Diseases of the brain have always carried a social and cultural stigma. These conditions continue to be seen as sign of weakness rather than an illness. It has been historically difficult for African Americans to trust health care providers, due, in many cases, to inept and inappropriate care. With mental illness the African American community was especially skeptical of treatment. Along with the shame and embarrassment of these conditions were fears and at times ignorance of what having a mental illness meant. Therefore African Americans relied on the options of prayer and private suffering (Bell, 2004). There has been and continues to be a lack of adequate community resources and support necessary for the comprehensive and successful treatment of depression especially in poor and underserved communities (Bell, 2004).

Religion

The majority of African Americans are Protestant of whom many follow the historically black churches. Black church refers to churches which minister to predominantly African American congregations. Black congregations were first established by freed slaves at the end of the 17th century, and later when slavery was abolished more African Americans were allowed to create a unique form of Christianity
that was culturally influenced by African spiritual traditions (Young, Griffin & Williams, 2003).

In a survey conducted by Thomas, Witherspoon, and Speight (2007), more than half of the African American population are part of the historically black churches, the majority are Baptist, with large numbers of Methodists and a few Pentecostals, while a fifth are part of Evangelical or mainline Protestant churches. There are 12 million African American Baptists distributed in four denominations, including the National Baptist Convention and the National Baptist Convention of America. There are 6 million Methodists; the largest sects are the African Methodist Episcopal Church and the African Methodist Episcopal Zion Church. Pentecostals are mainly part of the Church of God in Christ. About 16% of African American Christians are members of white Protestant communions, these denominations (which include the United Church of Christ) mostly have a 2 to 3% African American membership. The number of Roman Catholics is from 2.3 to 3 million. Of the total number of Jehovah's Witnesses, 22% are black.

Depression

Depression is a disease, a medical illness. It is the result of abnormalities in the brain that appear to be caused by extended periods of stress and duress, from which the brain is unable to re-establish its normal mood. It is actually a “multi system” disease. The brain controls multiple functions or systems, when impacted by depression, many of these functions or systems are disrupted. The result is a disease with a variety of symptoms that can interfere with a wide range of daily activities and functions (Mass-Robinson, 2001).
Depression, also known as depressive disorders or unipolar depression, is also a mental illness characterized by profound and persistent feelings of sadness and despair and/or a loss of interest in things that once were pleasurable. Disturbance in sleep, appetite, and mental processes are also common accompaniments (Gotlib & Hammen, 2009).

There are two main categories of depression: major depressive disorder (MDD) and dysthymic disorder (DSM-IV, 1994). Major depressive disorder is a moderate to severe episode of depression lasting two or more weeks. Individuals experiencing this major depressive episode may have trouble sleeping, lose interest in activities in which they once took pleasure, experience a change in weight, have difficulty concentrating, feel worthless and hopeless, or have a preoccupation with death or suicide (Solomon, 2001).

While major depressive episodes may be acute (intense but short-lived), dysthymic disorder is an ongoing, chronic depression that lasts two or more years (one or more years in children) and has an average duration of 16 years. The mild to moderate depression of dysthymic disorder may rise and fall in intensity, and those afflicted with the disorder may experience some periods of normal, non-depressed mood of up to two months in length. Its onset is gradual, and dysthymic patients may not be able to pinpoint exactly when they started feeling depressed. Symptoms of dysthymic disorder include a change in sleeping and eating patterns, low self-esteem, fatigue, trouble concentrating, and feelings of hopelessness (APA, 1994).

Dysthymia commonly occurs in tandem with other psychiatric and physical conditions (Gotlib & Hammen, 2009). Up to seventy percent of dysthymic patients have
both dysthymic disorder and major depressive disorder, known as double depression.
Substance abuse, panic disorders, personality disorders, social phobias, and other psychiatric conditions also are found in many dysthymic patients. Dysthymia is prevalent in patients with certain medical conditions, including multiple sclerosis, AIDS, hypothyroidism, chronic fatigue syndrome, Parkinson's disease, diabetes, and post-cardiac transplantation. The connection between dysthymic disorder and these medical conditions is unclear, but it may be related to the way the medical condition and/or its pharmacological treatment affects neurotransmitters. Dysthymic disorder can lengthen or complicate the recovery of patients also suffering from medical conditions (APA, 1994).

Depression also can occur in bipolar disorder, an affective mental illness that causes radical emotional changes and mood swings, from manic highs to depressive lows. The majority of bipolar individuals experience alternating episodes of mania and depression (Beck, 1997).

A hallmark of western medicine is its reliance on accurate diagnosis, the identification and classification of disease. An accurate diagnosis dictates the type of treatment and supportive care and it shed’s light on prognosis and course of illness. The diagnosis of a mental disorder is arguably the more difficult than diagnosing in other areas of medicine and health because there are no definitive pathological abnormalities or laboratory tests. Rather a diagnosis depends on a pattern of clustering of symptoms, i.e., subjective complaints, observable signs and behaviors associated with distress or disability (Gotlib & Hammen, 2009).
In the Handbook of Depression, Gotlib and Hammen (2009) state that the formal diagnosis of a mental disorder is made by a clinician and hinges upon three components; a patient’s description; signs from a mental status examination and a clinician’s observation and interpretation of the patient’s behavior including functional impairment. The final diagnosis rests on the clinician’s judgment about whether the patient’s signs, symptom patterns and impairments of functioning meet the criteria for a given diagnosis.

The American Psychiatric Association (APA) sets forth those diagnostic criteria in a standard manual known as the Diagnostic and Statistical Manual of Mental Disorders (DSM). This is the most widely used classification system both nationally and internationally for teaching, research and clinical practice (Maser, et al., 1991).

Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with nuances of an individual’s cultural frame may incorrectly judge as psychopathology those normal variations in behavior, beliefs, or experiences that are particular to individual’s culture (APA, 1994).

Etiology of Depression

According to Gotlib and Hammen (2009), causes behind depression are complex and not yet fully understood. While an imbalance of certain neurotransmitters, the chemicals in the brain that transmit messages between nerve cells, is believed key to depression, external factors such as upbringing (more so in dysthymia than major depression) may be as important. For example, it is speculated that, if an individual is
abused and neglected throughout childhood and adolescence, a pattern of low self-esteem and negative thinking may emerge, and from that, a lifelong pattern of depression may follow.

Heredity seems to play a role in the development of depression. Individuals with major depression in their immediate family are up to three times more likely to have the disorder themselves. Biological and genetic factors may predispose individuals to develop a depressive disorder, but environmental circumstances may often trigger the disorder (Solomon, 2001).

Cultural and social context weigh more heavily in causation of depression. In an international study by Cooper and Denner (1998), prevalence rates for major depression varied from two to nineteen percent across countries. This indicates that there is less inheritability for major depression.

Baker and Bell (1999) report that social and cultural factors, including exposure to poverty and violence, play a greater role in the onset of major depression. It is important to note that poverty, violence and other stressful social environments are not unique to any part of the globe, nor are the symptoms and manifestations they produce. However, factors often linked to race or ethnicity such as socioeconomic status or country of origin can increase the likelihood of exposure to these types of stressors.

Suicide rates and rates of depression vary among ethnic groups. The reasons for this wide divergence in rates are not well understood, but they are likely influenced by variations in the social and cultural contexts for each subgroup.

External stressors and significant life changes, such as chronic medical problems, death of a loved one, divorce or estrangement, miscarriage, or loss of a job often result in
a form of depression known as adjustment disorder. Although periods of adjustment disorder usually resolve themselves, occasionally the individual may develop major depression (Cooper & Denner, 1998).

Epidemiology of Depression

Surveying the level of depression in the general population has been difficult. Epidemiological studies that measure depression use two types of instruments, dimensional scales and structured interviews (Gotlib & Hammen, 2009).

The first modern North American general population epidemiological surveys that included information about depression were carried out in the late 1950s. In the Midtown Study (1962) and the Stirling County Study (1963). Researchers in these studies used dimensional screening scales of nonspecific psychological distress to pinpoint respondents with likely mental disorders, and then administered clinical interviews to the respondents. The outcome of primary interest was a global measure of mental disorder rather than individual diagnoses. No prevalence estimates of depression were reported. The screening scales in these studies however, included a number of items that assessed depressed mood and other symptoms that have subsequently become part of the depressive syndrome (Gotlib & Hammen, 2009).

In later surveys, variants on the screening scales used in the Midtown Manhattan and Stirling County studies were generally used without clinical follow-up. Scales scores were sometimes dichotomized to define “cases” of mental disorder based on external standard of a clinically relevant cut-point, although there was ongoing controversy about the appropriate decision rules to defining cases. To resolve this controversy, structured
diagnostic interviews appropriate for use in the community surveys were developed in the late 1970s. The Diagnostic Interview Schedule (DIS) was the first of these instruments as reported by Gotlib and Hammen (2009).

Dimensional scales continued to be widely used to screen for mental illness in primary care and to assess symptom severity and treatment effectiveness among patients in treatment for mental disorders even after the introduction of the DIS (Goldberg, 1972). However, psychiatric epidemiologists, influenced by the widely published results of the Epidemiologic Catchment Area Study (ECA) (Robin & Regier, 1991), which was based on the DIS, largely abandoned the study of dimensional distress measures in favor of dichotomous case classifications in general population surveys.

A structured interview (also known as a standardized interview or a researcher-administered survey) is a quantitative research method commonly employed in survey research. The aim of this approach is to ensure that each interview is presented with exactly the same questions in the same order. This ensures that answers can be reliably aggregated and that comparisons can be made with confidence between sample subgroups or between different survey periods (Patton, 1991).

During the past three decades community epidemiological surveys have used fully structured diagnostic interviews like the DIS, Composite International Diagnostic Interview (CISI) (Robin, Wing, et al., 1998), the Primary Care Evaluation of Mental Disorders (PRIME) (Spitzer, Williams, et al., 1994), and the Mini-International Psychiatric Interview (MINI) (Sheehan, Lecrubier, et al., 1998).

Structured interviews are a means of collecting data for a statistical survey. In this case, the data is collected by an interviewer rather than through a self-administered
questionnaire. Interviewers read the questions exactly as they appear on the survey questionnaire (Beck, Guth, Steer, & Ball, 1997). The choice of answers to the questions is often fixed (close-ended) in advance, though open-ended questions can also be included within a structured interview.

A structured interview also standardizes the order in which questions are asked of survey respondents, so the questions are always answered within the same context. This is important for minimizing the impact of context effects, where the answers given to a survey question can depend on the nature of preceding questions. Though context effects can never be avoided, it is often desirable to hold them constant across all respondents (Goodwin, Jacobi, Bittner, & Wittcher, 2006).

Gotlib and Hammen (2009) posit that fully structured diagnostic interviews, although useful are in and of themselves inadequate to provide the information needed by health policy planners concerning the magnitude of the problem of untreated depression. One of the main reasons that structured interviews are inadequate is that the criteria used are so broad that close to one-half of the people in the general population receive one or more diagnosis in a lifetime basis and close to one-fifth at any one point in time (Kessler, Berglund, Demler, Jin, Merikangas & Walters, 2005). According to Regier and Kaebler (1998), with prevalence estimates as high as these, the dichotomous case data provided in diagnostic interviews need to be supplemented with dimensional information on severity to be useful to health policy planners and researchers.

Another difficulty in measuring epidemiological prevalence of depression in the population is the use of various prevalence measures based on length of experience of
symptoms. There are three measures which are point prevalence, twelve month prevalence and lifetime prevalence (Kessler, et al., 1998).

Point Prevalence surveys report depressive symptoms during the recall period of 1 week to 6 months. Using this method Community surveys that assess depression found that up to twenty percent of adults and fifty percent of children and adolescents reported depression. The highest scores for depression were found among the youngest and the oldest population and the lowest among people in midlife (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005).

Many community surveys report 12 months prevalence of depression, which is defined as the percentage of respondents who had an episode of depression some time in the 12 months before the interview. Public health planning is typically made on an annual basis. Twelve-month prevalence of the DSM major depressive disorder was approximately seven percent equivalent to a national population projection of 13 million adults in the United States with 12 month depression (Kessler, et al., 2005).

Epidemiological surveys that administer diagnostic interviews generally assess lifetime prevalence of major depression and estimate age-of-onset distributions from retrospective reports. Lifetime prevalence of estimates of depression in the U.S. has ranged widely from as low as six percent prevalence to as high as twenty-five percent. Twelve month prevalence data estimates that more than 30 million adults in the United States have met the criteria for major depression at some time in their life (Kessler, et al., 2005).

Prevalence of major depressive disorder was significantly higher in Whites than in African Americans and Mexican Americans; the opposite pattern was found for
dysthymic disorder. Across racial/ethnic groups, poverty was a significant risk factor for major depressive disorder, but significant interactions occurred between race/ethnicity, gender, and education in relation to prevalence of dysthymic disorder (Goodwin, et al., 2006).

Co-Morbidity

Depression is a highly co-morbid disease. Studies of diagnostic patterns in community samples show that there is substantial lifetime and episode co-morbidity between depression and other mental and substance use disorders (Kessler & Bergland, 2003).

Kessler and colleagues (2005), in a national epidemiological study, report that co-morbidity is normal among people with depression. In that study nearly three-fourths of respondents with lifetime major depressive disorder also met criteria for at least one of the other psychiatric disorders assessed in the survey. This includes fifty-nine percent with at least one lifetime co-morbid anxiety disorder, thirty-two percent with at least one lifetime co-morbid impulse control disorder and twenty-four percent with at least one lifetime substance abuse use disorder.

Course of Depression

Discussing the course of depression in the population poses another hurdle for researchers and policy makers, when defining depression the DSM categorizes depression in terms of severity. Again the study results from Kessler and associates (2005) indicate that over ninety-nine percent of the respondents with twelve-month major depressive disorder were independently classified. Approximately eleven percent of
persons were classified with mild depression. Thirty-nine percent had moderate depression, thirty-eight percent had severe depression and thirteen percent had very severe depression. However, clinical depression may occur in conjunction with these conditions as well as other emotional and physical disorders such as hormonal, blood pressure, kidney, or heart conditions (American Psychiatric Association, 1994). A 2003 study reported that two-thirds of patients with major depression say they also suffer from chronic pain.

Impact on Society

The WHO in 2001, ranked depression as the single most burdensome disease in the world in terms of total disability-adjusted life years among people in the middle years. The Medical Outcomes Study (2009) was the first to report population-based studies to collect data on role impairment caused by depression by screening primary care patients over time to evaluate their medical costs and role functioning (Gotlib & Hammen, 2009).

The role impairments caused by major depression were comparable to those caused by seriously impairing, chronic physical disorders. Major depression was associated with the second largest number of days out of role impairment second only to chronic back/neck pain, and exceeding the number of days of role impairment associated with disorders such as arthritis, cancer and heart disease (Merikangas & Ames, 2007). A substantial part of role impairment caused by depression involves reduced work performance. Recent economic analysis of the costs of depression in the workplace estimated that the annual salary-equivalent of depression-related loss of productivity in
the United States exceeds $36 billion, including $11.7 billion due to excessive absenteeism and $24.5 billion due to reduced performance on the job. This estimate is probably smaller than the actual numbers because it does not include workplace costs. It excludes, effects of depression on performance of co-workers industrial accidents, turnover, and hiring and training costs (Kessler, Akiskal., et al., 2006).

Lifetime Issues and Transitions

The WHO (2001) reports that a substantially proportion of people with depression have onsets in childhood, adolescence and early adulthood that influence life course role transitions in an important way. One study found that early onset of depression prior to completing high school significantly predicted high drop out rate among high school graduates. Early onset of depression predicted failure to enter college, among respondents who went to college (Kessler, et al., 2006).

Early onset depression is also associated with increase of teenage pregnancy among boys and girls as well as elevated rates of failure to use contraception. A history of depression prior to marriage predicts both poor and marital quality and divorce. Welfare to work experiments have documented significant adverse effects of depression on making successful transitions from welfare to work (Danzgier & Carlson, 2001).

African Americans and Depression

There is the myth in the African American community that Black people are just sad or blue, that given the history of African American sadness is just accepted and not challenged. The phase blues people has been coined and the music genre of blues was started by African Americans as a way to express these feeling (Maass-Robinson, 2006).
African American still operate out of prejudice and ignorance when it comes to disease of the brain or mental illness. The African American Community have historically sought treatment less often, have been much sicker when finally forced to seek care and have had fewer treatment options when health care is needed (Maass-Robinson, 2004).

Diseases of the brain have always carried a social and cultural stigma. These conditions continue to be seen as a sign of weakness rather than an illness. It has been historically difficult for African Americans to trust health care providers, due to in many cases, to inept and inappropriate care. With mental illness the African American community was especially skeptical of treatment. Along with the shame and embarrassment of these conditions were fears and at times ignorance of what having a mental illness meant. Therefore African Americans relied on the options of prayer and private suffering (Bell, 2004).

There has been and continues to be a lack of adequate community resources and support necessary for the comprehensive and successful treatment of depression especially in poor and underserved communities (Bell, 2004). The prevalence of depressive disorders in African Americans is unclear. One of the problems for researchers and policymakers is adequately measuring the epidemiology of depression in African American communities. The data are contradictory in comparing the rates of depressive illness in African American and White persons. In 1999, researchers at the University of California–Berkeley reviewing six sites from the Epidemiologic Catchment Area data reported significantly lower rates of major depressive episodes, major depressive disorder, and dysthymia in African American and White persons (Gotlib & Hammen, 2009).
In 1999, researchers at the University of California–Berkeley reviewing six sites from the Epidemiologic Catchment Area data reported significantly lower rates of major depressive episodes, major depressive disorder, and dysthymia in African American as compared to White Americans (Zhang & Snowden, 1999).

Prevalence of major depressive disorder is significantly higher in Whites than in African Americans and Mexican Americans; the opposite pattern was found for dysthymic disorder. Across racial/ethnic groups, poverty was a significant risk factor for major depressive disorder, but significant interactions occurred between race/ethnicity, gender, and education in relation to prevalence of dysthymic disorder (Riolo, Nguyen, Greden, & King, 2005).

The National Health and Nutrition Examination Survey III examined depression prevalence by race and ethnicity across a nationally representative sample using the Diagnostic Interview Schedule (Riolo, Nguyen, Greden, & King, 2005). Again, lower rates of major depressive disorder (MDD) were found in African Americans than in White Americans, although the rates for dysthymia showed the opposite pattern.

Other studies, however, suggest an equal or greater prevalence of depressive disorders in African Americans. A 2004 study of 1,197 African American young adults ages 19 to 22 in Baltimore, Maryland found an overall prevalence of lifetime MDD was 9.4%, with women being 1.6 times more likely to report MDD than men (Jalongo, et al., 2004). This mirrors commonly accepted rates of depression in the general population. In St. Louis, Missouri, a 2004 study of middle-aged (ages 50–64) African Americans found 21% to have clinically relevant levels of depressive symptoms (Miller, et al., 2004). This
suggests an illness burden that is higher than the general population of depressive symptoms.

Regardless of actual prevalence, there is a significant illness burden from mental illness in the African American community. The suicide rate in young African American males is increasing significantly (U.S. Department of Health and Human Services, 2001). Additionally, African American patients with bipolar disorder were noted to have more psychiatric hospitalizations and more suicide attempts than White patients (Kupfer, et al., 2005).

African American Women

The poverty rate of single African American women living alone or with nonrelatives is very high. Older African American women are far more numerous than older African American men because of different mortality rates (O'Hare, 1996).

According to Carrington, (2006) statistics regarding depression in African American women are either non-existent or uncertain. Part of this confusion is because past published clinical research on depression in African American women has been scarce. This scarcity is, in part, due to the fact that African American women may not seek treatment for their depression, may be misdiagnosed, or may withdraw from treatment because their ethnic, cultural, and/or gender needs have not been met.

African American women may be reticent to participate in research studies because they are uncertain as to how research data will be disseminated or are afraid that data will be misinterpreted. In addition, there are few available culturally competent
researchers who are knowledgeable regarding the phenomenon of depression in African American women (Carrington, 2005).

Subsequently, African American women may not be available to participate in depression research studies. Available published statistics that African American women report more depressive symptoms than African American men or European American women or men, and that these women have a depression rate twice that of European American women (Kessler, et al., 1994). More African American women attend and complete college than men.

African American women have a triple jeopardy status which puts them at risk for developing depression. The majority-dominated society in the United States frequently devalues African American ethnicity, culture, and gender. In addition, African American women find themselves at the lower spectrum of the American political and economic continuum. They are involved in multiple roles as they attempt to survive economically for themselves and their families in mainstream society. All of these factors intensify the amount of stress within the lives of African American women which can erode self-esteem, social support systems, and health (Warren, 1994b).

The stereotypic portrayal of African American women as the epitome of “strength” and as long suffering, “motherly types” with limited individual needs is subscribed to by the majority culture. This is not to say that there are no behavior patterns that mesh with this stereotype. The difficulty lies more in the circumstances of increasing numbers of women of African ancestry, or in describing their behavior and accomplishments according to this stereotype. One insidious aspect of the stereotype is
the victim’s acceptance of the stereotypic description as reality with subsequent internationalization of this model (Young, 1989).

Black women experience rates of depression that are twice that of their male counterparts. Black women are also more likely to go without treatment, experience more severe symptoms, and seek help only at a point where their symptoms are debilitating (Carrington, 2006).

For many women, depression is experienced as feeling extremely irritable, sad, hopeless or guilty. Interest in activities that once were enjoyable, like spending time with friends or enjoying a hobby may diminish and now those things feel more like chores. Black women experience intimate partner violence at a rate thirty-five percent higher than that of white females, and at a rate 22 times higher than other races. Forty percent of Black women report experiencing abusive or coercive sexual contact by the age of 18. Fifty to ninety percent of all women who experience sexual harassment, rape, sexual abuse, coercion or molestation will develop symptoms of trauma including depression, anxiety, hopelessness, and decreased interest in enjoyable activities.

Many social factors contribute to experiencing symptoms of depression or other mental health problems. A 2001 Surgeon General's report said much of the depression and stress that women of color experience is a result of racism, gender bias, poverty, violence, large family size and social disadvantages. These social components, as well as the lack of culturally competent mental health services make getting help more difficult. Black women are often at a socioeconomic disadvantage in terms of accessing medical and mental health care. Approximately twenty percent of Black people are uninsured. Fannie Lou Hamer's statement about "being sick and tired of being sick and tired" is
quite relevant for Black women experiencing depression, since they often suffer from persistent, untreated physical and emotional symptoms (Williams, 2008).

When African American women are seen in physician’s offices, there is concern whether depression is recognized. In primary care settings, physicians were less likely to detect depression diagnoses in African Americans as compared to Whites (Borowsky et al., 2000).

According to studies when African American women consult health professionals, they are frequently told that they are hypertensive, run down, or tense and nervous. These women may be prescribed anti-hypertensive medications, vitamins, or mood elevating pills; or they may be informed to lose weight, learn to relax, get a change of scenery, or get more exercise. While these other things can be good advice, the root of their mental health symptoms frequently is not explored. These women continue to feel tired, weary, empty, lonely and sad (Carrington, 2006).

As a community, Black women are more likely to depend on family, religious and social organizations than on health or mental health professionals or other agencies that specialize in mental health services. Other women friends and family members may say, “We all feel this way sometimes, it's just the way it is for us Black women,” which often discourages African American women from seeking the help (Maass-Robinson, 2006).

African American Men

Current research suggests that African American men make up significant proportion of those affected by depression. A national study estimated the life time prevalence of depression among African American men to be seven percent but the
true number is probably higher, as studies have reported that depression is often under-diagnosed in African American patients (Cheung & Snowden, 1990; Whatley, 1997). This poses a significant problem for African American men, especially since depression, if not treated, can lead to suicide (Harris & Barraclough, 1997; U.S. DHHS, 2001; Joe, et al., 2006).

Suicide rates among African American men have steadily increased over the last several decades. Between 1950 and 2004, the age-adjusted suicide rate for Black males of all ages has increased by approximately 28%, as compared to a decrease of approximately 14% among comparable White males (U.S. DHHS, 2006). A national study reported that African American men ages 18 years and older have a lifetime prevalence of suicide ideation and suicide attempt of 10.2 % and 2.7 % respectively (Joe et al., 2006), and their risk of suicide persists into older adulthood.

Even more disconcerting is that African Americans men who experience suicide ideations and have psychiatric disorders attempt suicide at significantly higher rate than those without such disorders (Joe, et al., 2006). Despite these facts, research and mental health care to address the mental health needs of African American men have failed to keep pace with the prevalence of depression among this group.

Joe and colleagues (2006) found that until reaching their mid 20s, African American men had substantially lower rates of attempting suicide for the first time compared to African American women, Caribbean American women, and Caribbean American men. However, after the age of 34, African American men had the highest risk of attempting suicide of the sex by ethnicity groups under consideration.
Moreover, while peaks in the risk of first suicide attempt were exhibited by all four groups, for African American men and African American women the risk of suicide persisted into older adulthood (Joe, et al., 2006). The increase in suicide rates among African American men may be an indicator of the prevalence of depression as well as the need for mental health treatment among this population (U.S. DHHS, 2001).

An estimated 2.6% of African American men ages 18 and over suffered from serious psychological distress between 2003 and 2005; rates for White men of the same age and over the same time period are estimated to be similar, at 2.2 % (U.S. GHHS, 2006). Schizophrenia and depression with a focus on suicide are two mental illnesses experienced by African American men that have received the most attention in the literature.

The National Survey of American Life (NSAL), the largest mental health study of the non-institutionalized Black population ever conducted in the United States, reported that the estimated lifetime prevalence of major depression disorder (MDD) among African American men (7.0%) less than half that of White men (16.2%). Despite having a lower lifetime prevalence rate, however, for African Americans (56.5%) was greater than for Whites (38.6), and that African American with MDD were more likely to describe their condition as severe or very severe and as causing a greater degree of disability than whites with MDD. These findings, coupled with the fact that most African American (45.0%) with MDD do not received ant treatment, suggests that when Africans American men develop MDD, the disorder is more debilitating and persistent than it is for White men (Williams, et al., 2007).
Africans Americans are diagnosed with schizophrenia at rates higher than Whites, although this increase may be due in part to the under diagnosis of depression and the over diagnosis of schizophrenia among African Americans as compared to Whites (Cheung & Snowden, 1990; Whatley, 1997).

Cheung and Snowden (1990) reported that schizophrenia diagnosis rates among African Americans were sometimes twice as high as those for Whites, but that Whites were diagnosed with affective disorders (i.e. depression) at nearly twice the rate of African Americans. Whatley’s (1997) findings suggested that these racial differences in psychiatric diagnoses were due to diagnosticians’ misunderstanding of ethnic/racial differences in psychopathology. In any event, the existence of this racial difference among African American men is likely to be even higher than currently estimated.

Depression looks different in men and women. In the United States, a man is four times more likely than a woman to commit suicide, according to government statistics. Yet, he is only half as likely to be diagnosed with depression. That stark disconnect underscores a simple fact about depression in men: It often does not look like the mixture of sadness, guilt and withdrawal that dominates diagnostic descriptions and popular perception of the disease. As a result, a man's depression is often missed (Poussaint & Alexander, 2000).

But today the diagnosis of depression is in the midst of a long-overdue makeover, as medical and mental health professionals have come to recognize that in at least half of depressed men, the recognizable litany of symptoms don't really fit. Their way of weeping, some depressed men may be plagued by impotence and loss of sexual interest, but others may become wildly promiscuous. Many complain of depression's physical
symptoms -- sleep troubles, fatigue, headaches or stomach distress -- without ever discerning their psychological source. Compared to women suffering depression, depressed men are more likely to behave recklessly, drink heavily or take drugs, drive fast or seek out confrontation. Instead of acting like they are filled with self-doubt, depressed men may bully and bluster and accuse those around them of failing them. For many men, anger -- a masculine emotion that one "manages" rather than succumbs to -- is a mask for deep mental anguish. "That's their way of weeping," says psychologist William Pollack, director of the Centers for Men and Young Men at McLean Hospital in suburban Boston and an expert on depression in men.

Dr. Thomas Insel, director of the National Institute of Mental Health (2008), likens the shift now taking place among psychologists and psychiatrists to one that is taking hold in other areas of medicine. In the diagnosis of, say, heart disease, physicians have come to recognize that men and women can have the same illness, but their symptoms often look very different. Rage, substance abuse or reckless behavior all can be signs of the disease in men. Health professionals are expanding the definition as more men open up about their feelings. In any given year, says Insel, 6.4 million men will be diagnosed with depression -- and many health professionals think that number may be far too low. Insel's institute has launched a broad campaign to raise awareness of the depression that affects men.

The onset of depression among African American men is in part, related to the unique stressors they experience (Rich, 2000). Two such stressors are socioeconomic status (SES) and racial discrimination. SES stressors facing African American men include educational attainment, occupational status, income, and poverty. In 2005, 81.4%
of African American men completed high school or higher, but only 6.1% completed bachelors or higher degrees; the respective educational rates among White men were 89.9% and 32.3% (U.S. Department of Education, 2005).

In 2004, poverty rates among African American men were lowest for those working in management, professional and related occupations (2.9%) and highest for those working in service occupations, according to the U.S. Department of Labor (U.S.DOL) (2006). However, in 2005 African Americans occupied managerial, professional and associated positions at lower rates and service-related positions at higher rates than their white and Asians counterparts (U.S, DOL, 2005). Based on the 2009 second quarter findings, African American men aged 16 and over who were either full-time wage or salary worker earned $620 in median weekly earnings, which was less than weekly earnings of White men ($842) and Asian American ($909) men (U.S. DOL, 2009). Of the total number of African American men in the U.S. labor force in 2004, 8.4% approximately 621, 000, were estimated to be below the poverty level, a rate nearly two times greater than the rates for their White (4.6%) and Asian (4.8%) counterparts (U.S. DOL, 206).

Discrimination is another risk factor for depression. Clark and colleagues (1999) reported that perceived racism has a negative effect on the psychological well-being of African Americans. In a recent study examining the association of perceived racial discrimination and self-reported mental health, African American men who perceived experiences of discrimination self-reported higher levels of depressive symptoms and significantly lower levels of physical and mental health than their counterparts who did not perceived having experienced discrimination, a findings that remained following
adjustments for age, education and income (Borrell et al., 2006). More specifically, African American men reported worse physical health when they experienced discrimination at work, while discrimination in obtaining medical care associated with worse mental health.

Franklin and Boyd-Franklin (2000) contend that the repeated racial slights that are daily encountered by African American men can negatively affect their psychological well-being by creating a “psychological invisibility,” an intra-psychic process through which Black men come to feel as if they are not persons of worth.

The development of depression in African American men is affected by risk factors occurring during adolescence as well as during adulthood. Using longitudinal data from 892 African American males spanning a 14-year period, Mizell (1999) investigated factors that influence the development of depression in African American men over the life course. He found that low parental achievement (educational attainment, occupational status, social class), low adolescent self-esteem, lesser adult earnings and low levels of adult mastery (i.e., self-perception of control over their environment) are all contributing factors to higher level of adult depression for African American males.

Cultural Aspects of Depression

A hallmark of western medicine is its reliance on accurate diagnosis, the identification and classification of disease. An accurate diagnosis dictates the type of treatment and supportive care and it sheds light on prognosis and course of illness. The diagnosis of a mental disorder is arguably the more difficult than diagnosing in other areas of medicine and health because there are no definitive pathological abnormalities or
laboratory tests. Rather a diagnosis depends on a pattern of clustering of symptoms i.e. subjective complaints, observable signs and behaviors associated with distress or disability (Gotlib & Hammen, 2009).

In the Handbook of Depression, Gotlib and Hammen (2009) state that the formal diagnosis of a mental disorder is made by a clinician and hinges upon three components; a patient’s description; signs from a mental status examination and a clinician’s observation and interpretation of the patient’s behavior including functional impairment. The final diagnosis rests on the clinician’s judgment about whether the patient’s signs, symptom patterns and impairments of functioning meet the criteria for a given diagnosis. The American psychiatric association sets forth those diagnostic criteria in a standard manual known as the Diagnostic and Statistical Manual of Mental Disorders (DSM). This is the most widely used classification system both nationally and internationally for teaching, research and clinical practice (Maser, et. al, 1991). Depression is defined generally following the standards of the Diagnostic and Statistical Manual of Mental Disorders, currently in its fourth editions (American Psychiatric Association, 1994).

Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with nuances of an individual’s cultural frame may incorrectly judge as psychopathology those normal variations in behavior, beliefs, or experiences that are particular to individual’s culture. (APA, 1994).

Bazargan, Bazargan-Hejazi, and Baker (2005) conducted a study that consisted of eighty-eight percent female and fifty percent African American. They found that
thirty-two percent of participants who said they were suffering from depression had never presented to or been diagnosed by a physician. The gap between reporting a diagnosis and having that diagnosis was greatest for depression.

Gender and Cultural Issues

For years depression has been seen as a predominately “women's disease”. But today the diagnosis of depression is in the midst of a long-overdue makeover, as medical and mental health professionals have come to recognize that in at least half of depressed men, the recognizable litany of symptoms don't really fit (Ward & Collins, 2010).

Depression looks different in men and women. In the United States, a man is four times more likely than a woman to commit suicide, according to government statistics. Yet, he is only half as likely to be diagnosed with depression. That stark disconnect underscores a simple fact about depression in men: It often does not look like the mixture of sadness, guilt and withdrawal that dominates diagnostic descriptions and popular perception of the disease. As a result, a man's depression is often missed (Poussaint & Alexander, 2000).

Some depressed men may be plagued by impotence and loss of sexual interest, but others may become wildly promiscuous. Many complain of depression's physical symptoms -- sleep troubles, fatigue, headaches or stomach distress without ever discerning their psychological source. Compared to women suffering depression, depressed men are more likely to behave recklessly, drink heavily or take drugs, drive fast or seek out confrontation. Instead of acting like they are filled with self-doubt, depressed men may bully and bluster and accuse those around them of failing them. For
many men, anger is a masculine emotion that one "manages" rather than succumbs to (Ward & Cairney, 2010).

Baker and Bell (1999) report that social and cultural factors, including exposure to poverty and violence, play a greater role in the onset of major depression. It is important to note that poverty, violence and other stressful social environments are not unique to any part of the globe, nor are the symptoms and manifestations they produce. However, factors often linked to race or ethnicity such as socioeconomic status or country of origin can increase the likelihood of exposure to these types of stressors. Suicide rates and rates of depression vary among ethnic groups. The reasons for this wide divergence in rates are not well understood, but they are likely influenced by variations in the social and cultural contexts for each subgroup (Joe, et al., 2007).

Depression is defined generally following the standards of the Diagnostic and Statistical Manual of Mental Disorders, currently in its fourth editions (American Psychiatric Association, 1994).

Suicide and African Americans

Despite the widespread impact of self-directed violence or suicide in the United States, the problem has frequently been viewed as a one solely affecting European American males and the affluent (Earls, Escobar, & Manson, 1990). Among non-European Americans, only the incidence of suicide among Native Americans has been widely noted (U.S. Department of Health and Human Services [USDHHS], 1986).

There are several reasons for studying suicidal behavior among a variety of minority populations in the United States. It is a leading cause of premature death and
injury within these populations. Also, because European American suicide deaths represent more than 90% of the U.S. national total (Kachur, Potter, James, & Powell, 1995), the national rates and many of the risk and protective factors studied reflect patterns among that population and not necessarily those of African Americans.

Suicide was the 16th-leading cause of death overall in 2003 for African Americans. On an average day in the United States, one African American dies by suicide every 4.5 hours. There were 28,177 suicides recorded among African Americans from 1990 to 2003. The yearly number of suicides among African Americans (unless otherwise noted, figures cited for African Americans represent those for non-Hispanic African Americans) in the United States increased slightly by 2.1% from 1,879 in 1990 to 1,918 in 2003 (Centers for Disease Control and Prevention [CDC], 2005).

However, the age-adjusted suicide rate for this population declined 25% during the same period. The age-adjusted suicide rate was 7.15 deaths per 100,000 population in 1990 (all rates are per 100,000 population), which fluctuated in the early 1990s, but it has been declining since 1993 to 5.36 in 2003. Another measure of the scope of the suicide problem is by the years of potential life lost (YPLL) because of premature death. In 2003, suicide was the 10th-leading cause of YPLL before age 75 for African Americans, responsible for 73,065 YPLL (CDC, 2005).

The overall statistics on suicide among African Americans often masks the disproportionate impact of this health problem on specific subgroups within the population, especially males and females in the adolescent and young-adult age groups (Reese, Crosby, Hasbrouck, & Willis, 2004).
African American adolescents and young adults have the highest number and the highest rate of suicide of any age group of African Americans. Suicide was the third-leading cause of death among African American people aged 15 to 19 years, fourth among those aged 20 to 29 years, and eighth among those aged 30 to 39. Among African American adolescents and young adults, it is particularly the males that have the highest rates. During the early 1990s, the suicide rates among African American males aged 15 to 24 years were rising. The rates peaked in 1993 at 20.2, then began a steady decline to 11.6 (42.6% decrease) in 2002.

The number of completed suicides reflects only a small portion of the impact of suicidal behavior. Many more people are hospitalized because of nonfatal suicide attempts than are fatally injured, and an even greater number are treated in ambulatory settings or are not treated at all for injuries because of suicidal acts than those who are hospitalized (Rosenberg, et al., 1987). The comparative descriptions of suicidal ideation and behavior show some important differences; for example, the rate of suicide in males is higher than that in females, but studies of suicidal thoughts and nonfatal suicidal behavior (suicide attempts) routinely show females with higher rates (U.S. Public Health Service, 2001).

During 2004, the National Electronic Injury Surveillance System’s All Injury Program estimated that 49,119 African Americans were treated in U.S. hospital emergency departments for nonfatal self-inflicted injuries. Among African American females, 23,821 were seen for these injuries; for males, 22,298 were seen (CDC, 2005).

The Youth Risk Behavior Surveillance System is a school-based survey of health risk behaviors (including suicidal thoughts and behavior) among high school students. In
2003, African American high school students reported the following during the 12 months preceding the survey: For those who seriously considered suicide, the gender breakdown was: males 10.3%, females 14.7%; and for those who attempted suicide, it was: males 7.7%, females 9.0% (Grunbaum, et al., 2004).

Historically, suicidal behaviors among African Americans received scant attention because of the belief that very few African Americans completed suicide; it was also assumed that they did not experience depression. Blacks were historically viewed as a psychologically unsophisticated race that were naturally high spirited and unburdened with a sense of responsibility (Prudhomme, 1938; Prange & Vitols, 1962).

Some African American scholars also believed that suicide was not a problem in the African American community. Early and Akers (1993) did a qualitative study of African American ministers who felt that suicide was a “White thing” that was an anathema to a culture that was noted for its resiliency in the face of racial discrimination and oppression. Wright (1985) wrote a provocative essay entitled “Black Suicide: Lynching by Any Other Name,” in which he interpreted Black suicide as a method of genocide that was perpetuated and controlled by Whites and thus argued that there was no such thing as “Black suicide.”

Yet an examination of slave narratives and ship logs from the antebellum period quickly dispels the notion that Blacks rarely completed suicide or were too “happy” in their state of oppression to contemplate suicide. Lester (1998) noted that suicide was very common among slaves when they were captured in Africa, when they were being transported to the Americas, and immediately after their arrival. Many African tribes believed that their souls would return to Africa after death, so suicide was viewed as an
attractive alternative. Lester speculated that slave owners often mutilated the bodies of those who committed suicide because the slaveholders knew that the slaves believed their dismembered bodies could not return home.

Another factor that contributed to the dearth of research in this area is the assumption of universal expression of behaviors across cultures, what Nobles (1989) referred to as "transubstantiative error." It was not until 1979, that ethnic differences in suicide rates were depicted as "White" and "non-White." It was common practice to make no mention of the racial composition of the sample or to use White, middle-class control groups as though African Americans and Whites experience the same cultural and social reality. The assumption of universality makes it difficult to explore cultural differences in suicidal behaviors.

Interestingly, there is some limited evidence that there may be cultural differences in suicidality. Politano, Nelson, Evans, Sorenson, and Zeman (1986) found the behavioral component of depression, especially as it pertains to oppositionality, to be more prominently expressed in African American children. Delinquency has also been associated with suicide attempts among African American adolescent females (King, Raskin, Gdowski, Butkus, & Opipari, 1989; Summerville, Abbate, Siegel, Serravezza, & Kaslow, 1992).

Molock, Kimbrough, Blanton-Lacy, McClure and Williams (1994) found African American college students to be less likely to report suicide ideation and to report using alcohol or illicit drugs during a suicide attempt, and they also found a weaker relationship between suicide ideation and hopelessness when compared to White college students from similar socioeconomic backgrounds. Others have noted that African American
adolescents, when compared to other ethnic groups, may be less apt to report depressive symptoms or suicidal ideation even in the midst of a suicide crisis (Forbes et al., 1999; Morrison & Downey, 2000).

What has compounded the difficulty of studying suicides in African Americans is that their suicides are more likely to be misclassified than any other ethnic group (Phillips & Ruth, 1993; Warhauser & Monk, 1978). Others have wondered whether African American suicides may be "disguised" in the form of "victim-precipitated homicides" (Garrison, Addy, Jackson, McKeown, & Waller, 1991). Victim-precipitated homicide is viewed essentially as an act of suicide because the victim intentionally engages in behavior in a life-threatening context that almost guarantees that another person (e.g., police officer) will kill the victim (Parent, 1999; Wolfgang, 1958). Although it has been estimated that nearly 30% of urban homicides are victim-precipitated it is not formally recognized as a form of suicide (Van Zandt, 1993).

Some of the articles in this special edition are the first to present empirical findings on such important topics as cohort analyses on nationally representative samples of African Americans, African American suicide survivors, and African Americans who have made multiple suicide attempts. Joe and colleagues (2007) uses age-period-cohort analyses to attempt to shed some light on the factors that are responsible for the precipitous increase in rates of completed suicides among African American youth and young adults from 1980 to 2002. This sophisticated analytic strategy allows researchers to separate out the effects of age, time period at the time of death, and a person's birth cohort.
Joe and colleagues (2007) found significant cohort effects in his sample, noting that both the youth and the elderly, particularly among African American males, are at risk for completed suicides and warns that if the younger cohorts continue to carry their increased suicide risk status into later life, the recent decline in suicide deaths among youth may be reversed. The study (2007) further suggests that the deindustrialization of urban areas and its negative impact on the employability of young African American males, the disruptive onset of the crack cocaine epidemic in many urban cities, and the increased access to firearms may be responsible for the cohort effects we see in this data set.

Cosby and Molock (2009) examined hopelessness as a risk factor for near-lethal suicide attempts in African American and European American adolescents and young adults. Although African Americans actually reported lower levels of hopelessness when compared to the European Americans in her sample, hopelessness proved to be a stronger predictor of near-fatal suicide attempts among African American youth than among European American youth.

There is the often-cited belief that African Americans do not complete suicide. Most of the scholarship in this area has been based on anecdotal information or qualitative studies (Early & Akers, 1993). Walker and her colleagues were particularly interested in whether such lay beliefs (e.g., suicide is a sin) are culturally specific to African Americans (emic) or whether they represent a broader universal (etic) view of suicide beliefs regarding suicide. They examined lay beliefs, attitudes about suicide, and suicide ideation in African American and European American college students. Relative to European American students, African American students were significantly less likely
to attribute suicide to an interpersonal problem and more likely to believe that God, and not the individual, controls life and is responsible for life. The authors note that these differences in belief systems may reflect philosophical differences in worldview that potentially underlie African Americans' seeming “protection” from suicide via religiosity and religious and spiritual well-being and may account for the discrepant stress-suicide mortality rate for African Americans.

Although most of the research has focused on individuals who experience suicide ideation or engage in suicidal behaviors, to date, no one has looked at what happens to African Americans who have lost a loved one to suicide, people who are called “suicide survivors.” Donna Barnes presents a first-of-its-kind qualitative study about what happens to African American suicide survivors who have lost a family member to suicide. One of the resounding themes from this study is that the stigma associated with suicide in the Black community makes it extremely difficult for suicide survivors to get the help and support they need during their time of bereavement. Ironically, although religiosity and church attendance has been documented to be a protective factor against suicide across many ethnic communities, many of the survivors in this study report that Black churches were uncomfortable with openly dealing with the suicide of their family member or friend. This study provides an important voice for those who are suffering from the loss of a loved one to suicide and are struggling to get the support they need so they can put the pieces of their lives back together.

Nadine Kaslow and her colleagues (2006) compared the risk factors associated with suicide attempts in low-income African American women who were either first-time or repeat attempters. This study adds an important contribution to the field because
research suggests that repeat attempters probably are clinically very different from first time suicide attempters (Rudd, Joiner, & Rajab, 2001). To date, there is no empirical study that has examined these differences in an African American sample.

Kaslow and her colleagues (2006) found that repeat attempters had higher levels of suicide intent, created more detailed suicide plans, experienced more psychological distress, had more problems with substance abuse, and experienced more childhood trauma. They discuss the importance of developing culturally sensitive interventions that not only address the psychosocial vulnerabilities of these women but also focus on their strengths.

Most of the research that examines suicidal behaviors in the African American community focuses on delineating risk factors that are associated with suicidality. Molock and her colleagues (1994) examined some of the strengths in the African American community that might serve as protective factors against suicidal behaviors in the presence of factors that have been known to place youth at risk for suicidality. Their findings that hopelessness and depression were risk factors for suicidal thoughts and behaviors corroborate the general literature on suicide in adolescents. However, they also found that African American adolescents who used collaborative religious coping (the individual and God work together to solve problems) were more likely to attend church, were more active in church, tended to feel less hopeless and reported more reasons for wanting to live than did African American adolescents who used other religious coping styles.

In contrast, African American teens who used a self-directed religious coping style (God gives me the skills I need to solve my own problems) were less likely to
attend church and were more likely to feel depressed or hopeless and to report fewer reasons for wanting to live. The authors suggest that the use of a self-directed coping style may place African American adolescents at greater risk for depression and suicidality because this coping style may be less culturally compatible for African American teens (Cosby & Molock, 2008).

**Spirituality**

Spirituality and religion are gaining increased research attention because of their possible link to mental health promotion and mental illness prevention. Research findings while somewhat equivocal suggest that various aspects of religious practice affiliation and belief are beneficial for mental health (Mollock, et al., 1994).

When examining promotion or prevention of depression identification of modifiable risks and protective factors, i.e. characteristics of conditions that present increase of diminishing respectively the likelihood that people will develop mental health problems or disorders are important. The modifiability of a risk factor is a prerequisite for developing interventions targeting these factors. Such protective factors including spirituality, community and family support are important to African Americans (Martin & Martin, 2002).

Research findings are somewhat contradictory about whether spirituality is associated with less psychological distress and fewer symptoms of depression in adults. Idler (1987) conducted a long term study that examined whether the mother’s religion devotion was correlated with whether her children developed depression. The study found over a ten year period, that two factors were correlated with the children’s not
developing depression. These two factors were the mother's religiosity and her having the same religious denomination as her children.

The association between religious involvement and mental health also has been studied directly in African Americans. Using data from five large national samples, researchers found that African Americans report significantly higher levels of subjective religiosity, than do whites (Taylor, et al., 1999).

Other studies show that religious factors are strong predictors of life satisfaction for African Americans (St. George & McNamara, 1984; Thomas & Holmes, 1992). Studies also find that public and private aspects of religious involvement are associated with improved self-perceptions and self-esteem (Krause & Tran, 1989; Ellison, 1993).

Less is known about how religious or spiritual traditions relate to mental health. However, an interest in this process has led to the development of theories to guide empirical research. Some hypothesize that spirituality and religion influence health by adherence to health-related behaviors and lifestyles, by having an impact on marriage patterns, and hence heritability, by providing social support, by psychophysiology via ritual, or by promoting healthy cognitions via belief or faith (Krause & Tran, 1989; Ellison, 1993).

Arnette and colleagues (2007) conducted a study that examined religious involvement, spirituality, religious coping, and social support as correlates of posttraumatic stress symptoms and depression symptoms in African American survivors of domestic violence. Sixty-five African American women who experienced domestic violence in the past year provided data on demographics, severity and frequency of physical and psychological abuse during the past year, aspects of current social support,
types of current coping activities, religious involvement, spiritual experiences, and symptoms related to depression and posttraumatic stress disorder.

In this study, women who evinced higher levels of spirituality and greater religious involvement reported fewer depression symptoms. Religious involvement was also found to be negatively associated with posttraumatic stress symptoms. Women who reported higher levels of spirituality reported utilizing higher levels of religious coping strategies, and women who reported higher levels of religious involvement reported higher levels of social support. Results did not support hypotheses regarding social support and religious coping as mediators of the associations between mental health variables, religious involvement, and spirituality.

Spirituality has been identified as one component of a culturally competent therapeutic intervention for African American women. Dalmida (2006) designed a study to investigate the ability of factors, such as level of hopelessness and the use of positive religious coping strategies, to predict spiritual well-being overtime. Seventy-four low-income African American women were administered self-report questionnaires measuring hopelessness, use of religious coping strategies, and two domains of spiritual well-being. The study found that hopelessness; existential well-being, religious well-being and positive religious coping are correlated with one another. Further, lower levels of hopelessness predict increases in existential well-being over time; higher levels of positive religious coping predict increases in religious well-being overtime. Results were consistent with the study hypotheses and highlight the need to attend to predictors of spiritual well-being when implementing culturally relevant interventions with abused, suicidal African American women.
Spiritual beliefs and religious practices are used as coping mechanisms are more often than not related to enhanced mental health. In a review of studies assessing the impact of spirituality on mental health (Koenig, 2001) positive associations were found between religious beliefs/practices and indices of psychological well being, negative associations between religiousness and anxiety. Results regarding religiousness and depression are more mixed, but the majority of studies reviewed suggested a positive association between religiousness and psychological functioning.

Likewise, recent meta-analysis of 49 studies of religious coping revealed that positive religious coping is associated with more positive outcomes to stressful events, and less depression, anxiety, and general distress. With specific regard to depression, a second meta-analysis of 147 investigations showed that religiousness, particularly as manifest by an intrinsic religious orientation and use of positive religious coping was associated with fewer depressive symptoms. In addition religious beliefs have been associated with lower levels of hopelessness (Arnette, 2007).

Until recently research has focused more on religiosity than spirituality resulting in a relative deficit in understanding of the links between spirituality and emotional well-being in medical patients. Spirituality and emotional well-being are not mutually exclusive; however, religiosity is more concerned with adherence to an organized religion, where as spirituality focuses on the individuals search for meaning in life (Dessio, Wade, Chao, Kronenberg, Cushman, & Kalmuss, 2004).

Religiosity has been associated with increased well-being lower levels of depression and some evidence suggests this association is stronger for women than men. In medical patients religious beliefs and comfort derived from these beliefs have been
linked with lower depression levels while religious behaviors were not associated with depression. If depression is more strongly related to religious beliefs than to religious behavior; spirituality which includes the search for meaning and purpose within or outside of the organized religion may be highly related to depression levels (Larsen, 2006).

Studies investigating spirituality as a philosophy, attitude or outlook have found that medically ill patients who report greater spirituality have lower levels of depression. Larson (2006) studied of patients with end-stage pulmonary disease and found a relationship with between higher levels of spirituality discontent and high levels of depression. Some research suggests that spirituality may be particularly important for women diagnosed with cancer. However, the research has been largely qualitative and more research using quantitative methods is necessary to better understand this link. If spirituality is associated with depression in women with heart disease, this information could inform the development of effective psychosocial interventions for depression with this population.

In a study, Conners, White-side and Sherman (2006) examined the ties between religious variables and mental health in a high risk population: lower-income chemically dependent pregnant or parenting women participating in a residential treatment program. The primary goal was to investigate the relationship between various facets of religiousness and mental health symptoms, including depression and post traumatic stress. Negative religious coping was associated with greater PTSD symptoms, greater depressive symptoms and greater syndromal depressions after controlling for background demographic and addiction variables. Other aspects of religiousness,
including positive coping and involvement with organized religion, were not associated with mental health outcomes. These results suggest that negative aspects of religiousness, particularly religious struggle, merit greater attention from clinicians and investigators.

Women utilized religion and spirituality most often for serious conditions such as cancer, heart disease, and depression. African American women turning to spiritually based settings for counseling may not be appropriately referred to mental health treatment.

African American Clergy & Depression

In New Haven, Connecticut, a survey of African American clergy revealed frequent encounters with persons who suffered from mental health disorders (Young, Griffith, & Williams, 2003). Of the ninety-nine pastors who responded, two thirds of pastors reported involvement with suicidal persons. Two fifths of the pastors identified individuals with severe mental illness in their congregations, and sixty-three of nine-nine pastors had personally counseled individuals whom they considered dangerous to others. Though sixty-eight pastors were able to identify a mental health agency or professional who they would be comfortable referring patients too, only a quarter reported having made referrals to a social worker, emergency department, or public mental health agencies. Only fourteen of the ninety-nine pastors made referrals to psychiatrists.

The low rate of referral could be influenced by a lack of adequate information or understanding of mental illness. Almost fifty percent of the pastors agreed that people with severe anxiety or depression can cure themselves if they “put their mind to it.” When asked to rate the contribution of various items to the cause of mental illness, ninety
percent of the pastors identified stresses of living, eight-five percent cited unhealthy early family relationships. A lack of a “right relationship” with God was cited by seventy-two percent. While approximately sixty percent identified biological issues as a causative factor in mental illness, the same percentage listed stunted spiritual growth and/or un-confessed sin as causative factors as well. A more thorough understanding of the field of psychiatry and mental illness might facilitate clergy recognizing mental illness, and promote referral when appropriate to mental health agencies or health professionals.

In their book *Spirituality and the Black Helping Tradition*, Martin and Martin (2002) religious community is seen as a source of therapy and social support for African Americans. Spirituality is defined as the sense of the sacred and divine. Spirituality gave black people the strength to go on when there are threats to their very existence and, self worth and dignity when oppressive forces were seeking to strip them of their humanity, hope when there seemed to be none, a way when their was no way, and even joy when confronted by nothing but a daily rhythm of hardship, frustration and pain. In the face of the most demoralizing circumstances, spirituality gave Black people both the courage and encouragement and even in the mist of suffering and death, it gave them a will to live and the determination to make life worth living.

Furthermore, Martin and Martin state that people often do not make any distinctions between religiosity and spirituality. Both spirituality and religiosity in the minds of Black people are concerned with matters of the sacred or eternal, and divine; both dealt with issues of justice and injustice, good and evil, suffering and redemption, death and eternal life and right and wrong human conduct; and both involved a
relationship between a fragile, vulnerable people and an invisible, omnipotent higher power.

Treatment

Most mental health resources are currently dedicated to treatment modalities for depression. Yet research indicates that eighty percent of depressed people are not currently having any treatment and ninety-two percent of depressed African American males do not seek treatment.

The literature is unanimous in that African Americans are less likely to receive adequate mental health treatment (Wang, et al., 2005). The reasons for this disparity are not easily apparent, and likely represent a combination of factors including the recognition and diagnosis of depression in African Americans, as well as access and attitudes towards antidepressant medication in this population.

In some primary care settings, providers recognize depression and recommend treatment for African American patients at equal rates to White patients (Miranda & Cooper, 2004). However, even when recognized, African American patients were less likely to take antidepressant medications. Attitudes toward medications, particularly antidepressant medication, may contribute to this disparity. African Americans are less likely than Whites are to accept antidepressant treatment (Cooper, et al., 2003; Miranda & Cooper, 2004). African Americans have also been shown to prefer counseling over-medication for depression treatment (Dwight-Johnson, Sherbourne, Liao, & Wells, 2000).
African Americans are skeptical of mental health treatment in general and do avail themselves of mental health services. Despite the fact that African American men are burdened by depression, their rates of outpatient mental health services use remain low. A recent national study on data based form NSAL found that within the last 12 months, only 7.4% of African American men used any type of mental health services in response to problems with emotion, nerves, mental health or drug or alcohol use (Neighbors, et al., 2007). This was lower than 12 month mental health service use rates for African American women (12.2%), Caribbean American men (11.3%) and Caribbean American women (8.5%). Neighbors and colleagues also reported that among African American men with serious mental disorders, only 50.0% used any type of mental health services.

Traditional treatment

There are two major treatment modalities for depression: physical interventions, which include both pharmacological care and electroshock or electroconvulsive therapy (ECT) and psychotherapies or talking therapies. Reconciling the psychosocial and the psychopharmacological understanding of depression is difficult but necessary (Solomon, 2001).

Psychopharmacology

Antidepressant medications are recognized as acceptable forms of treatment of patients with mild to severe depressive disorders. The American Psychiatric Association (APA) treatment guidelines (APA, 2000) for major depressive disorder include psychiatric medication as a recommended initial treatment modality for moderate to
severe depression. For mild depression, psychiatric medication can be used if preferred by the patient. Psychotherapeutic intervention is indicated for mild to moderate depression characterized by the presence of significant psychosocial stressors, intrapsychic conflict, interpersonal difficulties, and co-morbid personality disorders.

In a sample that was sixty six percent African American and seventy-seven percent female, Sansone, Dunn, Worley, and Gaither (2003) explored patient attitudes towards various types of medications. Psychotropic medications were rated as less acceptable than non-psychotropic medications. Focus groups held by Cooper-Patrick and colleagues (1997) found that stigma and spirituality were significantly important factors in African American patient’s resistance to antidepressant medication. African American patients cited spirituality as a coping mechanism more frequently than do White patients. There were more comments regarding stigma as a barrier to seeking treatment in the African American group as well. Forty-three percent of African American women reported using religion/spirituality for health reasons in the past year in a national study (Dessio, et al., 2004).

Psychotropic medications are used more than any other type of treatment. It is quick and efficient. It is based on the philosophy that depression is an indication of a chemical imbalance. Anti-depressants take a long time to cause palpable changes. Only after two to six weeks will the depressed patient experience any real result from his shifted neurotransmitter levels. However studies show that antidepressants work for 35 to 45% of the depressed population, while more recent figures suggest as low as 30%.

Selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine (Prozac) and sertraline (Zoloft), reduce depression by increasing levels of serotonin, a
neurotransmitter. Some clinicians prefer SSRIs for treatment of dysthymic disorder. Anxiety, diarrhea, drowsiness, headache, sweating, nausea, poor sexual functioning, and insomnia all are possible side effects of SSRIs. A recent study shows this generation of drugs increases patients' risk of gastrointestinal bleeding.

Tricyclic antidepressants (TCAs) are less expensive than SSRIs, but have more severe side effects including persistent dry mouth, sedation, dizziness, and cardiac arrhythmias. Because of these side effects, caution is taken when prescribing TCAs to elderly patients. TCAs include amitriptyline (Elavil), imipramine (Tofranil), and nortriptyline (Aventyl, Pamelon). A 10-day supply of TCAs can be lethal if ingested all at once, so these drugs may not be a preferred treatment option for patients at risk for suicide.

Monoamine oxidase inhibitors (MAO inhibitors), such as tranylcypromine (Parnate) and phenelzine (Nardil), block the action of monoamine oxidase (MAO), an enzyme in the central nervous system. Patients taking MAOIs must avoid foods high in tyramine (found in aged cheeses and meats) to avoid potentially serious hypertensive side effects.

Heterocyclics include bupropion (Wellbutrin) and trazodone (Desyrel). Bupropion is prescribed to patients with a seizure disorder. Side effects include agitation, anxiety, confusion, tremor, dry mouth, fast or irregular heartbeat, headache, low blood pressure, and insomnia. Because trazodone has a sedative effect, it is useful in treating depressed patients with insomnia. Other possible side effects of trazodone include dry mouth, gastrointestinal distress, dizziness, and headache. In 2003, Well-butrin's
manufacturer released a once-daily version of the drug that offered low risk of sexual side effects or weight gain.

Electroconvulsive Therapy

ECT, or electroconvulsive therapy, usually is employed after all therapy and pharmaceutical treatment options have been explored and exhausted. However, it is sometimes used early in treatment when severe depression is present and the patient refuses oral medication, or when the patient is becoming dehydrated, extremely suicidal, or psychotic.

The treatment consists of a series of electrical pulses that move into the brain through electrodes on the patient's head. ECT is given under general anesthesia and patients are administered a muscle relaxant to prevent convulsions. Although the exact mechanisms behind the success of ECT therapy are not known, it is believed that the electrical current modifies the electrochemical processes of the brain, consequently relieving depression. Headaches, muscle soreness, nausea, and confusion are possible side effects immediately following an ECT procedure. Memory loss, typically transient, has also been reported in ECT patients. ECT causes severe memory problems for months or years in one out of every 200 patients treated.

Psychotherapy

Psychotherapy can be effective in treating clinical depression, especially depression that is less severe. Scientific studies have shown that short term (10-20 weeks) courses of therapy are often helpful in treating depression.
Psychotherapies come out of psychoanalysis, which in turn comes out of the ritual disclosure of dangerous thoughts first formalized in the Church confessional. Psychoanalysis is a form of treatment in which specific techniques are used to unearth early trauma that has occasioned neurosis. It usually requires a great deal of time; four or five times a week is standard. Psychotherapy focuses on bringing the content of the unconscious mind to light. Psychoanalysis is good at explaining things, but it is not an efficient way to change them (Solomon, 2001).

The purpose of the psychoanalytic process is to examine one's life. For many years talking about depression was considered the best cure for it. The role of the doctor is to listen closely and attentively while the client gets in touch with his true motivations, so that he can understand why he acts as he does. Most psychodynamic therapies are based on the principle that naming something is a good way to subdue it and that knowing the source of a problem is useful in solving that problem. Such therapies, also teach strategies for harnessing knowledge to ameliorative use (Solomon, 2001).

Based on Freud's clinical observations and treatments of patients from middleclass white, European and Jewish backgrounds many have found his theories of questionable value in treating black American patients. It has been hypothesized that Freud's theories are applicable to other ethnic and cultural groups but the way these theories are applied reduces their functional utility. There have been reports that blacks and other ethnic groups have differing symptomatology of depression.

Two kinds of psychotherapy that have the best record for treatment of depression are cognitive–behavioral therapy (CBT) and interpersonal therapy (IPT). CBT is a form of psychodynamic therapy based on emotional and mental responses to external events,
in the present and in childhood. CBT is tightly focused on objectives. The system was
developed by Aaron Beck and is now used throughout the United States and most
Western Europe. Beck proposes that one’s thoughts about oneself are frequently
destructive and that by forcing the mind to think in certain ways one can actually changes
one’s reality--it’s a program that one of his collaborators has called “learned optimism.”
He believes that depression is the consequence of false logic and that by correcting
negative reasoning one may achieve better mental health. CBT teaches objectivity. The
patient learns to distinguish between what actually happens and her ideas about what
happens. CBT teaches the art of self-awareness. Cognitive-behavioral therapy is broadly
used today, and is seems to show some significant effect on depression.

There also seem to be some good results from interpersonal therapy (IPT). This
treatment regimen was formulated by Gerald Klerman, at Cornell and his wife Myrna
Weissman at Columbia. IPT focuses on the immediate reality of current day-today life.
Rather than working out an overarching schema for an entire personal history, it fixes up
things in the present. It is not about changing the patient into a deeper person, but rather
about teaching the patient how to make the most of whoever he is. It is a short-term
therapy with short-term boundaries and limits. It assumes that many people who are
depressed have had life stressors as the trigger or consequences of their depression and
that these can be cleaned-up through well advised interaction with others.

Treatment is in two stages. In the first stage the patient is taught to understand
depression as an external affliction and is informed about the prevalence of the disorder.
His symptoms re sorted out and named. He takes the role of the sick one and identifies a
process of getting better. The patient makes up catalogs of all his current relationships,
and with the therapist defines what he gets from each one and what he wants from each one. The therapist works with the patient to figure out what the best strategies are for eliciting what is needed in his life. Problems are sorted four categories: grief differences about the role with close friends and family (what you give and what you expect in return for example); states of stressful transition in personal or professional life (divorce or loss of job, for example); and isolation. The therapist and the patient then establish few attainable goals and decide how long they will work toward them. IPT lays out your life in even, clear terms (Solomon, 2001).

Though CBT and IPT have specific strengths, any therapy is only good as the practitioner. The therapist matters more than your choice of therapeutic system. Someone whom you connect profoundly can help you a lot just by chatting with you in an unstructured environment; someone to whom you do not connect will not really help you no matter how sophisticated his technique or how numerous his qualifications.

In an important study done in 1979, researchers demonstrated that any form of therapy could be effective if certain criteria were met: That both the therapist and the patient acted in good faith; that the client believed that that the therapist understood the technique; and that the client liked and respected the therapist; and that therapist had an ability go form understanding relationships. The experimenters chose English professors with this quality of human understanding and found that on average the English professors were able to help their patients as much as the professional therapists.
Non-traditional Treatment

Non-traditional treatments are ways of dealing with depression that are not sanctioned by the medical community but are used to respond to depressive symptoms. These include attending parties, consuming alcohol, talking with a friend, changes in eating patterns and sleeping patterns (Tomes, et al., 1990).

A variety of alternative medicines have proven to be helpful in treating depression. A recent report from Great Britain emphasized that more physicians should encourage alternative treatments such as behavioral and self-help programs, supervised exercise programs, and watchful waiting before subscribing antidepressant medications for mild depression. Chocolate, coffee, sugar, and alcohol can negatively affect mood and should be avoided. Essential fatty acids may reduce depression and boost mood. Expressing thoughts and feelings in a journal is therapeutic. Aromatherapy, particularly citrus fragrance, has had a positive effect on depression. Psychotherapy or counseling is an integral component of treatment because it can find and treat the cause of the depression.

Instead of reaching out for support, a person experiencing depression might find that eating, sleeping, drinking alcohol or using drugs "helps"—or at least seems to dull the pain for the moment. Other people find themselves sleeping too much or too little, feeling fatigued, having a hard time concentrating, or even having thoughts of suicide. African Americans have the ability to be creative and use methods to overcome uncomfortable feeling and other psychological feelings. Nontraditional methods are ways African Americans have to manage stress. These treatments are behaviors by the individuals that result in reducing to tolerable limits physiological and psychological
manifestations of emotional arousal during and shortly after the stressful event and mobilizes the individual's internal and external resources and develops new capabilities in him that lead to changing his environment or his relationship to it, so that he reduces the threat or finds alternative sources of satisfaction for what is lost (Caplan, 1981).

The National Institute on Drug Abuse found that over sixty percent of people who abuse drugs and alcohol also suffer from a mental disorder. Using drugs is a common survival skill for those who have experienced trauma, violence or abuse. Over twenty-five percent of Black children who are exposed to violence meet the criteria for Post-Traumatic.

Since the early days of slavery, Blacks have developed self-medicating strategies. Dance and music are excellent therapies. "Juke Joints" were like mental clinics. And there was always the alcohol drug that could be administered. The Black church is a primary source of therapy. The "Black community" by definition is an elaborate coping devise that is why mentioning that one has a mental illness leads to rejection because that term for us is redundant. I never have met a black person who has not been depressed at least one a week. If you got a hundred dollars instead of going to a psycho therapist put it in the collection plate - healing comes with a great show and music too.

There is very little research focusing on the coping strategies used by African American men in response to depression. The research that does exist has revealed, however, that although they use mental health services at a low rate, African American men use various strategies to cope with mental health problems. In the National Survey of Black Americans (N=1.136, 375 males), the following coping strategies were used most frequently By African Americans men in response to emotional problems; Facing
the problem/doing something (85%) seeking informal help from family friends (74.4%) prayer (72.9), keeping busy (69.9%), trying to relax (69.2%) and trying to forget (63.9%; Broman, 1996). Although drinking or getting high (i.e., using marijuana) was the coping strategy used least frequently in response to emotional problems (18.0%), it was also a strategy that was significantly more likely to be used by African American men than by their female counterparts (Broman, 1996).

Treatment Effectiveness

NSC-R data reports that approximately sixty-seven percent of respondents received treatment for depression within a 12 month period. Treatment met conventional standards for adequacy based on minimal concordance with published treatment guidelines. This means that only twenty-one percent of all people with 12 month major depression receive adequate treatment. There is clear evidence that depression treatment that fails to conform with treatment guidelines is associated with incomplete recovery and increased risk of recurrence.

The results document serious problems in treatment of people with depression in the United States. Increasing use for some modalities, most notably pharmacotherapies and physician administered psychotherapies over the past decade has generated hope that depression might now be treated much more effectively than in the past. Mental health service use remains disturbingly low both because a substantial proportion of cases do not receive adequate care and because many of those who successfully access health care fail to get adequate treatment according to established treatment guidelines Gotlib & Hmmen, 2009).
The frequent use of treatments with uncertain benefits is striking. This is especially worrisome with complementary-alternative medicine (CAM) treatments (e.g. energy healers, massage therapists) that account for a substantial minority of all visits for treatment of depression despite a paucity of data supporting their efficacy. A challenge for providers of conventional services is to determine why CAM has such great appeal and whether legitimate aspects related to this appeal can be adopted by conventional mental health care providers to increase the attractiveness of evidence-based treatments.

On the positive side the proportion of NCS-R respondents with depression who reported mental health service is considerably higher than in previous decades. Increasing awareness of mental disorders on the part of primary care physicians, coupled with an increase in consumer demand stimulated by direct-consumer advertising, has probably also played a role in this growth (Kroenke, 2003).

Nevertheless, the fact that only a small minority of patients treated in the general medical sector receives even minimally adequate care makes these trends concerning. Reasons for low rate of treatment adequacy are unclear, but they presumably involve both provider and patient factors. Provider factors include competing demands, inadequate reimbursements for treating depression, less training and experience in treating depression. Patient factors include worse compliance with treatments than in mental health specialty sectors.

African American men’s treatment seeking behavior and coping behaviors in response to mental health illness are affected by their attitudes towards mental illness and the mental health system. Sussman, Robins, and Earls (1987) investigated racial differences in the tendency to seek treatment for depression, and found African
Americans compared to Whites were more likely to avoid seeking care due to distrust of treatment and fear of being hospitalized. Similarly, Ward and Besson (2009) found that African American men believed that having a mental illness can result in negative outcomes such as being hospitalized to placement in corrections.

While not specific to mental health, a focus group study reported that distrust of physicians among African American patients was due to several factors, including a lack of interpersonal competence, lack of technical competence, perceived greed, racism and beliefs about experimentation (Jacobs, Rolle, Ferrans, Whitaker & Warnecke, 2006). Trusting relationships between physicians and Black patients encouraged openness, honesty and adherence to treatment recommendations, while distrust was associated with lack of adherence, avoidance of care, and even withdrawal from care (Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2006). Consistent with these findings, Whatley (2004) suggested that mental health professionals’ cultural biases and negative stereotypes about Black men may have caused the poor treatment seeking behavior and mistrust of the mental health system exhibited by African American men.

Despite the low use of mental health services among African Americans, the National Comorbidity Survey (NCS) revealed that prior to utilization of mental health services, the attitudes of African Americans toward seeking services was more positive than that of Whites. These attitudes included inclination to seek care, level of comfort with seeking care and level of comfort with seeking care, and level of comfort with friends knowing they were seeking care. These findings held true for African Americans in general populations as well as those diagnosed with major depression. After receiving mental health services, however, African Americans were more likely than Whites to
have negative attitudes about such services, displaying decreased odds of going back to receive further services due to continued illness, as well as decreased comfort with friends knowing that they sought professional care (Diala, et al., 2000).

Barriers

The stigma associate with mental illness is another barrier to obtaining treatment among African Americans. The surgeon General’s report on mental health recognized stigma related to the receipt of mental health services as one of the foremost causes of underutilization, particularly among racial minority groups (U.S. DHHS, 2001).

A recent qualitative study revealed that African Americans harbor stigmas about persons with mental illness and that these beliefs negatively influenced their mental illness treatment-seeking behaviors (Sanders Thompson, Bazile, & Akbar, 2004). Research suggests that African American hold more negative attitudes about mental illness than Whites (Cooper-Patrick, Powe, & Jenckes, 1997: Silva de Crane & Spielberg, 1992). Other studies posit that African Americans are more likely than Caucasians to perceive individuals with mental illness as dangerous, that is as persons who commit violent acts against others (Whatley, 1997; Anglin, Link, & Phelan, 2006).

In a nationally representative study, Whatley (1997) found that the perception of dangerousness held by African Americans toward mentally ill individuals persisted even when their contact with mentally ill people was increased. Increased contact with mentally ill individuals was however, associated with reduced stigma among Whites (Whaley, 1997). While African Americans were significantly more likely than Caucasians to view mentally ill individuals as dangerous, the belief that individuals with
mental illness should be blamed for punished for their violent behavior was significantly less likely to be held by African Americans than their Caucasian counterparts, a finding that persisted after controlling for socio-demographic factors (Anglin, Link, & Phelan, 2006).

There has been and continues to be a lack of adequate community resources and support necessary for the comprehensive and successful treatment of depression especially in poor and underserved communities (Bell, 2004).

**Conceptual Framework**

A focus on the individual, isolated and independent, is deeply embedded in the culture and values of American society. Causal theories of depression have been used across all populations. Cognitive-behavioral theory which is one of the primary theories of depression is based on the idea that one’s thoughts cause feelings and behaviors, not external things, like people, situations, and events. This and other theories have utilized biological, psychosocial, and sociological weaknesses and changes to explain the occurrence and development of depression.

Blacks have been evaluated with theories and models of the mind and with psychological evaluation tools originally developed by members of other ethnic groups, who did not take into consideration black cultural differences. The assumption is that these theories and psychological requirements are applicable to all groups of people regardless of ethnic or cultural differences have not been adequately assessed.

The conceptual framework for this study is based on an Afro-centric perspective, a strengths perspective which emphasizes the importance of cultural aspects of defining
and explaining depression. According to the literature protective factors including spirituality, community and family support are important to African Americans in managing psychological trauma.

The Afrocentric paradigm is predicated on traditional African philosophical assumptions that emphasize the interconnectedness and interdependency of natural phenomena. From this perspective all modalities and realities are viewed as one, there is no demarcation between the spiritual and material, substance and form (Schiele, 1990).

Historical experiences are so pivotal to understanding ethnic identity and current health status. The monstrous legacy of slavery profoundly interrupted the normal course of psychological development of African Americans including immigrants from the Caribbean and West Indies whose ancestors were enslaved (Latif & Latif, 1994).

The Afrocentric perspective focuses on the resilience of African Americans their supportive families, strong communities, spirituality and religion. Spirituality is a protective factor that promotes resiliency in African Americans. African Americans tend to take active approaches to facing personal problems, rather than avoiding them (Broman, 1996) They are more inclined than whites to depend on handling distress on their own (Sussman et al., 1987) They also appear to rely more on spirituality to help them cope with adversity and symptoms of mental illness. (Brown 1996).

While it is important to realize that blacks differ from one and another in attitudes, values, folkways, mores, ethnic identity, religious beliefs, diet, language, social class, family history and other distinguishing characteristics of groups of people it is also apparent that the ethnic aspects of African Americans lifestyle shows a richness and diversity that is quite unique from other ethnic groups in America.
One example is how Black Americans differ from other American ethnic groups can be found in various beliefs and behaviors that form the body of black folk medicine. In addition to differences in belief systems about illness, other readily examples include diet, music and language. There are clear indications that a number of vestiges of Black culture and slavery in found in Black American groups today.

African Americans use various activities or treatments to alter their state of consciousness. These treatments are behaviors by the individuals that result in reducing to tolerable limits physiological and psychological manifestations of emotional arousal during and shortly after the stressful event and mobilizes the individual’s internal and external resources and develops new capabilities in him that lead to changing his environment or his relationship to it, so that he reduces the threat or finds alternative sources of satisfaction for what is lost (Caplan, 1981).

In more recent psychiatric literature, there is much more attention placed on altered states of consciousness and the adaptive functions contained therein. Butts (2007) makes it clear that drugs, religion, and sex, three vehicles for altering states of consciousness are all valid attempts to gain temporary release from daily living via an excursion into an altered state of consciousness. There has been a great bulk of work investigating psychotherapy, meditation, and states of consciousness with resultant beliefs that meditation produces relaxation, global desensitization, lowering of cortical and autonomic arousal and clearer conceptual thinking in both normal and mentally retarded persons.

In looking at Blacks cosmology, one finds that blacks from many different countries have similar beliefs about the structure of their world and have similar
techniques for altering their states of consciousness for them to navigate through the stress of their intrapsychic, interpersonal and environmental interactions.

In keeping with the notion that unnatural acts exist, black folklore understands that there are natural acts that are the work of all being right in God's world. As a result Black cultural techniques for altering states of consciousness are an attempt to remain in harmony with one's universe and prevent harm from downfall.

Christian Black culture has a technique of altering one's state of consciousness to an expanded state by letting the spirit of God, in the form of the Holy Ghost, enter and heal the body of all its woes. Griffith describes this method as in a prayer meeting in which participants sang entered trance states, shouted and testified. Blacks seek to alter there states of consciousness also through rhythms such as dancing, music, and singing in an attempt to gain harmony with their universe.

In addition, physical exertion aids in developing internal scanning skills, which allows for greater physiologic control over responses to stress and provides a practice ground for performing under stress and developing skills of concentration. In some instances, it stimulates mental imagery and problem solving capabilities.

It seems that one of life's universal principles is to try and heal whatever ails it an done method man has developed to aid in his survival is discovering and using techniques to alter states of consciousness. Blacks have traditionally used alter states of consciousness to help establish harmony with their environment and protect themselves from harmful forces both spiritual and natural in their universe.

They have also used altered states of consciousness to help themselves develop creative solutions for problems they face and alleviate dysphoric effects of stress, thus
rendering them better able to eliminate the source of stress. Finally, African Americans use altered states of consciousness to help redirect their life toward a more rewarding future. African Americans are culturally, historically and spiritually using altered states of consciousness to better survive their life circumstances.
CHAPTER III

METHODOLOGY

Chapter III presents the methods and procedures that will be used in conducting the study. The following are described: research design; description of the site; sample and population; instrumentation; treatment of data and limitations of the study.

Research Design

A descriptive and explanatory design was used in this study. The study was designed to obtain data on the perception of depressive symptoms, spirituality, traditional and nontraditional treatment modalities among African Americans.

The descriptive and explanatory design allowed for descriptive analysis of the demographic characteristics of the sample. Even though ethnicity will be the same for all study participants, descriptive analysis will provide a comprehensive description of differences in income, age, perception of depression, spirituality, traditional and nontraditional treatment modalities for depression among the respondents to the survey.

The explanatory element of this design will facilitate the explanation of the statistical relationship between perceptions of depression, spirituality, traditional and nontraditional treatment among African Americans.
Description of Site

This research was conducted in Atlanta, Georgia. Atlanta is the largest metropolitan city in the State of Georgia. This survey was administered in Ray of Hope Christian Church which is a large church with approximately five thousand members after service on two consecutive Sundays in June of 2009. The majority of members of the church were African American.

Sample and Population

The target population for this research study was African Americans with no history of a medical/clinical diagnosis of depression. The non-probability convenience sample of two hundred and four respondents were African American women and men who participated religious services at Ray of Hope Christian Church in Atlanta, Georgia. Two hundred respondents were selected using non-probability convenience sampling.

Instrumentation

The research study employed a survey questionnaire entitled *Depression Spirituality and Treatment*. The survey questionnaire consists of two sections with a total of thirty-six (36) questions. Section I solicited demographic information about the characteristics of the survey respondents. Section II of the survey solicited the perceptions of the respondents and consisted of questions that assessed the respondent’s perception of depressive symptoms, spirituality, traditional and non-traditional treatment modalities for depression.

Section I of the survey questionnaire consisted of eight questions (1 thru 8). Of the eight questions, selected questions were used as independent variables for the study.
The questions in Section I were concerned with gender, age group, racial category, marital status, education, employment, type of employment income and insurance status. These questions provided information for the presentation of a demographic profile on the respondents of the research study.

Section II consisted of twenty-eight questions (9 thru 38) which were divided into four subsections. These subsections presented seven questions that defined and explained the four variables of depression, spirituality, traditional treatment and nontraditional treatment for depression. The question in subsection entitled depression. These questions are derived from symptoms listed in the psychiatric Diagnostic and Statistical Manual (DSMIV) of mental illness required for a diagnosis of mental illness. These symptoms are mood disturbance, cognitive disturbance, vegetative symptoms (i.e. sleep, appetite) and somatic complaints (i.e. headaches, pain etc.)

Sub-section entitled spirituality consisted of seven questions that related to faith, prayer, and participation in religious services or ceremonies. These included prayer, meditation, attendance at religious services, reading the bible or daily devotionals and talking to the pastor.

Sub-section entitled traditional treatment consisted of seven questions from the literature on the available traditional treatment modalities. Traditional treatment and consists of questions related to seeking professional health, taking medications, homeopathic remedies, calling a hotline and exercising.

The subsection entitled nontraditional treatments for depression consisted of seven modalities in the literature defined as nontraditional treatments that are relevant to
the sample population. These included, talking with a friend, eating, shopping, increased sleeping and consuming alcohol.

Items in Sections II require responses that are based on a four point Likert scale. The scale is as follows: 1 - Strongly Disagree; 2 – Disagree; 3 – Agree; 4 – Strongly Agree.

Treatment of Data

Statistical treatment of the data employed descriptive statistics, which include measures of central tendency, frequency distributions and cross tabulations. The test statistics for the study will be Phi (Φ), and chi square test statistics.

Frequency distribution was used to analyze each of the variables of the study in order to summarize the basic measurements. A frequency distribution of independent variables was used to develop a demographic profile and to gain insights about the respondents of the study.

Cross tabs were utilized to demonstrate the statistical relationship between independent and dependent variables. Cross tabulations were conducted on depression, spirituality, traditional and non-traditional treatment modalities among the African American women and men in the study.

Two test statistics were employed. The first test was Phi (Φ) which is a symmetric measures of associations that is used to demonstrate the strength of relationships between two or more variables (Knoke & Bohnstedt, 1995). The following are the values associated with Phi (Φ):
.00 to .24  "no relationship"
.25 to .49  "weak relationship"
.50 to .74  "moderate relationship"
.75 to 1.00 "strong relationship"

The second test statistic employed in the research study was chi square. Chi Square was used to test whether or not there was a statistical significance at the .05 probability among the variables in the study.

Limitations of the Study

One limitation of the study is that a non-random sample with self-selected participation by the respondents. The sample is drawn from participants with a college education or middle class and will not represent poor African Americans. This conclusion may not be relevant to other populations.

Depression symptoms were based on self-report of the sample and did not involve a structured interview by a clinician or trained researcher. Since the sample consisted of participants in religious services there maybe a religious bias.

This study does address cultural barriers that might impact the report of depressive symptoms such as stigma.
CHAPTER IV
PRESENTATION OF FINDINGS

The purpose of this chapter is to present the findings of the study in which describe and explain the perceptions of depression, spirituality, treatment among African Americans. The findings are organized into three sections: demographic data, overview of the four variables, depression, spirituality, traditional treatment and nontraditional treatment. The third section consists of the statistical analysis of the research questions and hypotheses.

Demographic Data

This section provides a profile of the study respondents. Descriptive statistics were used to analyze the following: gender, age, ethnicity, marital status, employment status, education level achieved, yearly income and whether or not the participants had health insurance.

A target population for the research was composed of adult African Americans within the age range of 19 to 60 and over, who attend a large metropolitan church in Atlanta, Georgia. Two hundred and four participants were selected utilizing convenience sampling from among participants of the selected site. Membership at the church was not a criterion for participation in the study. However, participants who had a history of medical/clinical diagnosis of depression were excluded from the study.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>86</td>
<td>42.2</td>
</tr>
<tr>
<td>Female</td>
<td>118</td>
<td>57.8</td>
</tr>
<tr>
<td>Ethnicity</td>
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</tr>
<tr>
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<td>1.0</td>
</tr>
<tr>
<td>African American</td>
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<td>95.1</td>
</tr>
<tr>
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<td>0.5</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Other</td>
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</tr>
<tr>
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<tr>
<td>19-29</td>
<td>25</td>
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</tr>
<tr>
<td>30-39</td>
<td>45</td>
<td>22.1</td>
</tr>
<tr>
<td>40-49</td>
<td>53</td>
<td>26.0</td>
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<tr>
<td>50-59</td>
<td>59</td>
<td>28.9</td>
</tr>
<tr>
<td>60 &amp; over</td>
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<tr>
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<tr>
<td>Married</td>
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</tr>
<tr>
<td>Divorced</td>
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<tr>
<td>Widowed</td>
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<td>2.5</td>
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<tr>
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<tr>
<td>Part-time</td>
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<tr>
<td>Homemaker</td>
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<tr>
<td>Retired</td>
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<td>9.3</td>
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<tr>
<td>Educational Level</td>
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<tr>
<td>Less than high school</td>
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<tr>
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<tr>
<td>Some college &amp; tech school</td>
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<td>29.9</td>
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<tr>
<td>College graduate</td>
<td>103</td>
<td>50.5</td>
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Table 1 continued…

Demographic Profile of Study Respondents

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<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yearly household income</td>
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</tr>
<tr>
<td>Less than $20,000</td>
<td>24</td>
<td>11.8</td>
</tr>
<tr>
<td>$20,000 – 39,999</td>
<td>51</td>
<td>25.0</td>
</tr>
<tr>
<td>$40,000 – 59,999</td>
<td>48</td>
<td>23.5</td>
</tr>
<tr>
<td>$60,000 – 69,999</td>
<td>20</td>
<td>9.8</td>
</tr>
<tr>
<td>$70,000 &amp; up</td>
<td>61</td>
<td>29.9</td>
</tr>
<tr>
<td>Health Insurance</td>
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<td></td>
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<tr>
<td>Yes</td>
<td>175</td>
<td>85.8</td>
</tr>
<tr>
<td>No</td>
<td>29</td>
<td>14.2</td>
</tr>
</tbody>
</table>

As indicated in Table 1, the typical respondent was an African American female between the ages of 40 to 59, who was married and employed full-time. Also, the typical respondent was a college graduate who had health insurance and an annual household of $70,000. Male participants in the study totaled eighty two or forty two percent. Female respondents totaled one hundred eighteen or approximately fifty eight percent. The total number of identified Africans Americans was 194, with 2 Caucasians, 1 Native American and 1 Hispanic. There were 6 respondents who self identified as other. Approximately eighty-six percent of the respondents had health insurance.

Perception of Depression among African Americans

This section consists of seven questions that indicate whether or not the respondents are experiencing depressive symptoms. The symptoms include feelings of sadness, insomnia, problems with concentration, changes in appetite, and feelings of
fatigue and lost of interest in daily activities. Respondents must respond positively to experiencing at least four of these symptoms to meet the criteria to be diagnosed with depression (Beck, 1969).

Table 2
Perceptions of Depression Among African Americans

<table>
<thead>
<tr>
<th>Question</th>
<th>Disagree #</th>
<th>Disagree %</th>
<th>Agree #</th>
<th>Agree %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9 I feel sad most of the time</td>
<td>190</td>
<td>93.1</td>
<td>14</td>
<td>6.9</td>
</tr>
<tr>
<td>Q10 I have trouble falling asleep</td>
<td>156</td>
<td>76.5</td>
<td>48</td>
<td>23.5</td>
</tr>
<tr>
<td>Q11 I wake up frequently</td>
<td>148</td>
<td>72.5</td>
<td>56</td>
<td>27.5</td>
</tr>
<tr>
<td>Q12 I have difficulty concentrating</td>
<td>175</td>
<td>85.8</td>
<td>29</td>
<td>14.2</td>
</tr>
<tr>
<td>Q13 I have experienced loss of appetite</td>
<td>176</td>
<td>86.3</td>
<td>28</td>
<td>13.7</td>
</tr>
<tr>
<td>Q14 I feel tired most of the time</td>
<td>144</td>
<td>70.6</td>
<td>60</td>
<td>29.4</td>
</tr>
<tr>
<td>Q15 I have lost interest in daily activities</td>
<td>179</td>
<td>87.7</td>
<td>25</td>
<td>12.3</td>
</tr>
</tbody>
</table>

As indicated in Table 2 the majority of respondents did not report any symptoms of depression, such sadness, sleep disturbance, difficulty concentrating, change in appetite, feeling tired or loss of interest in activities. However according to data from the Department of Health nationally roughly twenty percent of Americans reports symptoms of depression. These questions were above the national average in positive responses. Question 10: I have trouble falling asleep received approximately twenty four percent positive responses. Question 11: I wake up frequently received approximately twenty eight percent positive responses. Question 14: I feel tired most of the time received approximately thirty percent positive responses.
Spirituality among African Americans

This section consists of seven questions that indicate the perception of spirituality and depression among African Americans. The seven questions are identify various activities, prayer, church attendance, religious readings or consultation with the pastor or spiritual advisors. Positive responses indicate that the respondents perceive spirituality as a positive response to depression (Dalmida, 2006).

Table 3

Perceptions of Spirituality Among African Americans

<table>
<thead>
<tr>
<th>Q</th>
<th>Question</th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Q16</td>
<td>Spirituality help me cope when I am depressed</td>
<td>51</td>
<td>25.0</td>
</tr>
<tr>
<td>Q17</td>
<td>I pray when I am depressed</td>
<td>46</td>
<td>22.5</td>
</tr>
<tr>
<td>Q18</td>
<td>I meditate when I am depressed</td>
<td>80</td>
<td>39.2</td>
</tr>
<tr>
<td>Q19</td>
<td>I participate in spiritual services – depressed</td>
<td>66</td>
<td>32.4</td>
</tr>
<tr>
<td>Q20</td>
<td>I talk with my pastor when depressed</td>
<td>135</td>
<td>66.2</td>
</tr>
<tr>
<td>Q21</td>
<td>I read the bible when I am depressed</td>
<td>83</td>
<td>40.7</td>
</tr>
<tr>
<td>Q22</td>
<td>I read daily devotionals when depressed</td>
<td>81</td>
<td>39.7</td>
</tr>
</tbody>
</table>

As indicated in Table 3 the majority of respondents reported that spirituality is important in managing depression among African Americans. However, the majority of the respondents reported that they would not talk with their pastor when feeling depressed (66%). Approximately sixty eight percent of the respondents participate in spiritual services when they are depressed.
Perceptions of Traditional Treatments for Depression Among African Americans

This section consists of questions regarding the traditional treatments or treatments that are prescribed and sanctioned by the medical community. These include seeking professional help, taking prescription medications, exercising, writing in a journal and using homeopathic remedies (Clarington, 2006).

Table 4

Perceptions of Traditional Treatment Among African Americans

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Q23 When I am depressed I seek professional help</td>
<td>163</td>
<td>79.9</td>
</tr>
<tr>
<td>Q24 When I am depressed I take anti-depressants</td>
<td>179</td>
<td>87.7</td>
</tr>
<tr>
<td>Q25 When I am depressed I participate in counsel</td>
<td>164</td>
<td>80.4</td>
</tr>
<tr>
<td>Q26 When I am depressed I call the crisis line</td>
<td>183</td>
<td>89.7</td>
</tr>
<tr>
<td>Q27 When I am depressed I exercise</td>
<td>126</td>
<td>61.8</td>
</tr>
<tr>
<td>Q28 When I am depressed I write in a journal</td>
<td>142</td>
<td>69.9</td>
</tr>
<tr>
<td>Q29 When I am depressed I use homeopathic</td>
<td>173</td>
<td>84.8</td>
</tr>
</tbody>
</table>

As indicated in Table 4 the majority of the respondents report that they would not seek traditional forms of treatment for depression. A very small proportion of five percent reported that they would take anti-depressant medication. These findings are consistent with the data that African American do not seek treatment for depression (Gotlib & Hammen, 2009).
Perception of Non-Traditional Treatment Among African Americans

Non Traditional treatments are ways of dealing with depression that are not sanctioned by the medical community but are used to respond to depressive symptoms. These include attending parties, consuming alcohol, talking with a friend, changes in eating patterns and sleeping patterns (Tomes, et al., 1990).

Table 5

Non-Traditional Treatment Among African Americans

<table>
<thead>
<tr>
<th>Question</th>
<th>Disagree #</th>
<th>Disagree %</th>
<th>Agree #</th>
<th>Agree %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q30 When I am depressed I use home remedies</td>
<td>172</td>
<td>84.3</td>
<td>32</td>
<td>15.7</td>
</tr>
<tr>
<td>Q31 When I am depressed I talk to a close friend</td>
<td>72</td>
<td>35.3</td>
<td>132</td>
<td>64.7</td>
</tr>
<tr>
<td>Q32 When I am depressed I drink alcohol</td>
<td>179</td>
<td>87.7</td>
<td>25</td>
<td>12.3</td>
</tr>
<tr>
<td>Q33 When I am depressed I shop</td>
<td>152</td>
<td>74.5</td>
<td>52</td>
<td>25.6</td>
</tr>
<tr>
<td>Q34 When I am depressed I go out- parties etc</td>
<td>149</td>
<td>73.5</td>
<td>55</td>
<td>27.0</td>
</tr>
<tr>
<td>Q35 When I am depressed I eat</td>
<td>131</td>
<td>64.2</td>
<td>73</td>
<td>35.8</td>
</tr>
<tr>
<td>Q36 When I am depressed I sleep</td>
<td>132</td>
<td>64.7</td>
<td>72</td>
<td>35.3</td>
</tr>
</tbody>
</table>

As indicated in Table 5 the majority of the respondents indicated that they would not use non-traditional forms of treatment if they were depressed. However, as noted in question 31 roughly sixty-five percent of respondents reported that would talk to a close friend if they were depressed. This finding is consistent with the oral traditional among African American especially African American women (Wade & Collins, 2010).
Research Questions and Hypotheses

There were four research questions and null hypotheses in the study. This section provides an analysis of each research question and tests the null hypotheses.

Research Question 1: Do African American women and men report symptoms of their depression?

Hypothesis 1: There is no statistically significant difference between the number of African American women and men who report symptoms of their depression.

Table 6 is a cross tabulation of depression and gender. It shows the association between gender and depression and whether there is statistically significant relationship gender and depression.

Table 6
Comparison of Report of Depressive Symptoms between women and men.

<table>
<thead>
<tr>
<th>Depression</th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>111</td>
<td>54.4</td>
<td>7</td>
</tr>
<tr>
<td>Male</td>
<td>86</td>
<td>42.2</td>
</tr>
<tr>
<td>Total</td>
<td>197</td>
<td>96.6</td>
</tr>
</tbody>
</table>

$\Phi = .161$  
$df = 1$  
$\rho = .022$
As shown in Table 6, approximately fifty-four percent (111) of women and forty-two percent of men did report depressive symptoms. Where as approximately three percent of women reported depression and none of the male participants reported depression. The statistical measurement phi (Φ) was employed to test for the strength of the relationship between gender and depression. As indicated there is no relationship (Φ = .161) between gender and depression. When the chi-square statistical test for significance was applied, the null hypotheses was not rejected indicating that there is a significant statistical difference in the report of depression between women and men.

Research Question 2: Do African American women and men rely on spiritual practices when depressed?

Hypothesis 2: There is no statically significant difference between the number of African American women and men rely on spiritual practices when depressed.

Table 7 is a cross tabulation of gender and spirituality. It shows whether there is an association between spirituality and gender and whether or not the relationship is statistically significant.
Table 7

Comparison of Report of Spirituality between women and men.

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Female</td>
<td>65</td>
<td>31.9</td>
<td>53</td>
</tr>
<tr>
<td>Male</td>
<td>54</td>
<td>26.5</td>
<td>32</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
<td>58.3</td>
<td>85.0</td>
</tr>
</tbody>
</table>

Φ = .077   df = 1   ρ = .270

As shown in table 7 approximately twenty three percent of women and sixteen percent of men relied on their spirituality during periods of depression. The statistical measurement phi (Φ) was employed to test the strength of the association between gender and spirituality. As indicated in the table there is no relationship (Φ = .077) between gender and spirituality. The chi-square statistical test was applied the null hypotheses is accepted (p = .270). There is no significant statistical difference in the use of spirituality between men and women.

Research Question 3: Do African American women and men use traditional forms of treatment when depressed?

Hypothesis 3: There is no statically significant difference between the number of African American women and men use traditional forms of treatment when depressed.
Table 8 is a cross tabulation of traditional treatment for depression and gender. It shows whether there is a relationship between the two variables and the strength of the relationship.

Table 8
Comparison of Report of Traditional Treatment between women and men.

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th></th>
<th>Agree</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td></td>
<td>#</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>109</td>
<td>53.4</td>
<td>9</td>
<td>4.4</td>
<td>118</td>
<td>57.8</td>
</tr>
<tr>
<td><strong>Male</strong></td>
<td>82</td>
<td>40.2</td>
<td>4</td>
<td>2.0</td>
<td>86</td>
<td>42.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>191</td>
<td>93.6</td>
<td>13</td>
<td>6.4</td>
<td>204</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Φ = .061  \( \Phi = .061 \)

As indicated in Table 8 the statistical measurement of phi (Φ) was employed to test for the strength of association between the traditional treatment for depression and gender.

As indicated in table 8 there is no relationship (Φ = .061) between gender and the use of traditional treatments for depression. When the chi square statistic is employed to test for significance the null hypotheses is accepted (p = .390). There is no significant difference in the use of traditional treatment among men and women.
Research Question 4: Do African American women and men use nontraditional forms of treatment when depressed?

Hypothesis 4: There is no statically significant difference between the number of African American women and men use nontraditional forms of treatment when depressed.

Table 9 is a cross tabulation of the use of non-traditional treatment by gender. It shows the association of the use of non-traditional treatment by gender and whether or not there is a statistically significant relationship between the variables.

Table 9
Comparison of Report of Non-Traditional Treatment between women and men.

<table>
<thead>
<tr>
<th>Depression</th>
<th>Disagree</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Female</td>
<td>111</td>
<td>54.4</td>
<td>7</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>41.7</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>196</td>
<td>96.1</td>
<td>7</td>
</tr>
</tbody>
</table>

\[ \Phi = .121 \quad \text{df} = 1 \quad \rho = .083 \]

As indicated in Table 9 the statistical measurement of phi (\( \Phi \)) was employed to test for the strength of associations between the use of non-traditional treatment and gender. As indicated there no relationship (\( \Phi = .121 \)) between the use of non-traditional treatment for depression and gender. When the chi-square statistical test for significance
was applied, the null hypotheses is accepted (p = .083) indicating that there was no statistically significant difference in between gender and the use of non-traditional treatment at the .05 level of probability.

In summary the sample of 204 respondents was a middle class sample of college educated African Americans who attended a large Christian Church with over three thousand members. Forty-two percent (86) of the sample were male and fifty-eight percent (118) of the sample was comprised of females. Sixty-six percent (134) of the sample was over forty years of age. Forty-two percent (86) of the sample were currently married. Seventy-six percent were employed full-time. Fifty percent (103) of the sample were college graduates. Over sixty-three percent of the respondents had annual incomes of forty thousand or more. Eighty-six percent of the respondents had health insurance.

There was no relationship between gender and any of the variables, depression, spirituality, traditional and nontraditional treatment of depression. There was a statistically difference in of reporting of depressive symptoms between men and women. However, there was no statistically difference between gender and the perception of spirituality, the use of traditional and non-traditional treatments for depression.
CHAPTER V
CONCLUSIONS AND RECOMMENDATIONS

The research study was designed to answer four questions concerning the perceptions of depression, spirituality, traditional treatment and nontraditional treatment among African Americans with no history of a medical/clinical diagnosis of depression. The conclusions and recommendations of the research findings are presented in this chapter. Recommendations are proposed for future discussions for policy makers, social workers, practitioners and administrators. Each research question is presented in order to summarize the significant findings of interest.

Research Question 1: Do African American women and men report symptoms of their depression?

In order to determine if African American women were depressed, Depression was defined using seven questions based on the DSM-IV symptoms criteria for a diagnosis of depression. These seven symptoms were analyzed. Depression was computed based on the calculation of these seven symptoms.

The majority of the respondents did not report depressive symptoms but when examined individually approximately one fourth of the respondents reported the following symptoms of sleep disturbance which had two related question on the survey. sleep disturbance. Forty eight respondents or twenty eight percent of the respondents
reported 'trouble falling asleep'. Fifty-six respondents or (28%) respondents reported 'waking up frequently.' Finally, sixty of respondents (29%) reported 'feeling tired most of the time. The psychological symptom of 'feeling sad was reported only by fourteen respondents (6.9%). This is consistent with the literature which reports African Americans report more physical symptoms than psychological symptoms (Dalmilda, 2006).

The statistical measurement phi (\( \Phi \)) was employed to test for the strength of the relationship between gender and depression. As indicated there was no relationship (\( \Phi = .161 \)) between gender and depression. When the chi-square statistical test for statistical significance was applied (\( p = .002 \)), the null hypotheses was not rejected indicating that there is a statistical difference in the report of depressive symptoms between women and men. Women report more symptoms of depression than men (****).

Research Question 2: Do African American women and men rely on spiritual practices when depressed?

Seventy-five percent of the respondents reported that spirituality helped them cope with depression. "I talk with my pastor when depressed" was the only question in this section to received less that fifty percent (33.8%) affirmative responses. Indicating that spirituality is used to cope by African Americans when depressed. When the spirituality variable is cross-tabulated by gender.

The spirituality variable was cross tabulated by gender and the statistical measurement phi (\( \Phi \)) was employed to test for the strength of the relationship between gender and depression. As indicated there is no relationship (\( \Phi = .161 \)) between gender and depression. When the chi-square statistical test for significance was applied, the null
hypothesis is accepted ($p = .077$) indicating that there was no statically difference in the use of spirituality between women and men when depressed.

Research Question 3: Do African American women and men use traditional forms of treatment when depressed?

The majority of the sample replied negatively to the use of traditional treatment interventions for depressions. However, approximately one third of the respondents reported that that exercised and wrote in a journal when depressed. This would be in line with the data that African Americans are proactive in managing depression.

When the statistical measurement of phi ($\Phi$) was employed to test for the strength of association between the traditional treatment for depression and gender, ($\Phi = .061$) there is no relationship between gender and the use of traditional treatments for depression. When the chi-square statistic is employed to test for significance ($p = .390$) the null hypotheses is accepted indicating that there is no statically difference in the use of traditional treatments by men and women.

Research Question 4: Do African American women and men use non-traditional forms of treatment when depressed?

When examining non-traditional treatments among African Americans approximately sixty-five percent reported that that would talk to a friend when depressed. When the statistical measurement of phi ($\Phi$) was employed to test for the strength of associations between the use of non-traditional treatment and gender, ($\Phi = .121$) there was no relationship between the use of non-traditional treatment for depression and gender. When the chi-square statistical test for significance was applied, the null hypotheses is accepted ($p = .083$) indicating that there was no statistically significant
relationship between gender and the use of non-traditional treatment at the .05 level of probability.

Discussion

This sample for this study was representative of an affluent group of African Americans. As noted in the literature review, African Americans have made tremendous gains. This sample has access to income, education and health care. However, the results of the study are consistent with current literature. African Americans do not report depressive symptoms, or seek treatment for depression. This sample was similar to the literature in that more women reported depression symptoms as indicated in the literature. No relationships between spirituality, and the use of traditional and non-traditional treatment. Since the majority of the sample had access to health care lack of insurance was not a barrier. The responses to not access treatment for depressive symptoms may be attributed to bias and stigma related to mental illness.

Recommendations

As indicated earlier. There are few studies on African Americans and depression. The reason for this is difficult to ascertain. But clearly more studies are needed. This study asked some pertinent questions about depression and again raises issues on defining depression, spirituality and treatments both traditional and non-traditional from a cultural perspective relevant to the African Americans.

As a result of the findings of this study, the researcher is recommending the following:
1. There is a need for epidemiological research to clarify the specific prevalence of depression among African Americans particularly African American men.

2. Due to concerns about misdiagnosis and under-diagnoses of African Americans it is imperative that health care systems and providers are culturally competent. Literature suggests that cultural competence in health care can support quality improvement and eliminate racial/ethnic disparities in mental health care.

3. Due to the reports of low use of mental health treatment and services and high prevalence of stigma in the African American community more community outreach tailored specifically for African American men is needed.

4. Outreach should focus on educating African Americans about mental illness, the health outcomes of having an untreated mental illness and treatment options.

The church is a source of strength in the African American community. Africans Americans use diverse strategies to cope with mental illness, praying and seeking support from informal networks. Outreach should be conducted in collaboration with the Black church and family oriented. Ministers and pastors will play a vital role in educating the African American Community about depression.
APPENDIX A

Letter to the Ray of Hope Church

January 6, 2009

Dr. Cynthia L. Hale, Senior Pastor
Ray of Hope Christian Church
2778 Snapfinger Rd
Decatur, Ga. 30034

Dear Dr. Hale:

I am a student in the Ph.D. program at the Whitney M. Young Jr., School of Social Work at Clark Atlanta University. I am writing to request your permission to include members of your congregation in research for my dissertation entitled: *A Study of the Perceptions of Depression, Spirituality and Treatment Among African American Women*. The purpose of the research is to obtain information about the experiences and/or attitudes about depression, spirituality and treatment for depression of African American women.

African American women members of your congregation will be asked to complete a questionnaire: *Depression, Spirituality & Treatment* after a Sunday Worship Service. The questionnaire will take approximately five to ten minutes to complete. No incentives will be provided and participation in the research is completely voluntary. All information obtained will remain private, confidential and physically secured.

There are no known risks to participants who agree to take part in this research. There are no known personal benefits to participants who agree to take part in this research. However, it is hoped that those who participate in this study will advance research in the field of social work.

Your consideration in this matter is greatly appreciated. Thank you in advance for your consideration of this request.

Sincerely

Vickie M. Jester LCSW
404-377-7052
vickiejester@bellsouth.net

Cc: Dr. Richard Lyle
APPENDIX B

Response from Ray of Hope Church

June 16, 2009

Vickie Jester
2029 Mark Trail
Decatur, Georgia 30032

Re: Research Project

Dear Ms. Jester,

Thank you for taking the time to share with me, information regarding your research project. It was a pleasure to hear about your academic endeavors and we are honor that you would like for us to be a part of this project.

I have shared your research project with our Executive Pastor and permission has been granted to administer your research questionnaire to members of the church. I will begin communicating this to the various ministries and space has been reserved for you at the front desk.

Best wishes,

Helen P. Branch
Minister of Outreach and Pastoral Care
APPENDIX C

Consent Form

A Study of the Perceptions of Depression, Spirituality & Treatment Among African Americans

You are invited to participate in a brief survey. The survey entitled: Depression, Spirituality & Treatment, will take approximately five to ten minutes to complete. The purpose of the survey is to obtain information about your attitudes about depression, spirituality and treatment for depression.

There are no known risks to participants who agree to take part in this research. There are no known personal benefits to participants who agree to take part in this research. However, it is hoped that those who participate in this study will advance research in the field of social work.

All responses to the questionnaires will remain private, confidential, and physically secured. Participation in this study is voluntary. However, if you have been medically diagnosed with depression in past it is asked that you do not take part in this study. If you have questions about this study, you may contact the principal investigator- Vickie M. Jester by e-mail at: vickiejester@bellsouth.net or the Clark Atlanta University School of Social Work at 404-880-8006.

My signature below verifies that I have read the statement above and agree to participate in this research project.

Print Name ___________________________ Signature ___________________________ Date ________

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APPENDIX D

Survey Questionnaire

DEPRESSION, SPIRITUALITY & TREATMENT

SECTION I  Demographic Information
Place a mark [x] next to the appropriate item. Choose only one answer for each question.

1. What is your Gender?
   1. ___ Male
   2. ___ Female

2. Which of the following best describes your Ethnicity?
   1. ___ Caucasian
   2. ___ African American
   3. ___ Asian American
   4. ___ Hispanic
   5. ___ Native American
   6. ___ Other

3. Which of the following best describes your Age group?
   1. ___ 19-29
   2. ___ 30-39
   3. ___ 40-49
   4. ___ 50-59
   5. ___ 60- over

4. Which of the following best describes your Marital Status?
   1. ___ Never married
   2. ___ Married
   3. ___ divorced
   4. ___ Widowed

5. Which of the following best describes your current Employment Status?
   1. ___ Full-time
   2. ___ Part-time
   3. ___ Homemaker
   4. ___ Unemployed
   5. ___ Retired
APPENDIX D

(continued)

6. What is the highest level of Education you completed?
   1. ___ Less than high school
   2. ___ High School Graduate
   3. ___ Some college/technical school
   4. ___ College graduate

7. What is your yearly household Income?
   1. ___ Less than $20,000
   2. ___ $20,000 to $39,999
   3. ___ $40,000 to $59,999
   4. ___ $60,000 to $69,999
   5. ___ $70,000 or over

8. Do you have health insurance?
   1. ___ Yes
   2. ___ No

SECTION II: This section asks questions about the symptoms of depression, spirituality, traditional and nontraditional ways of treating depression. Write the appropriate response number in the blank beside each statement using the following scale:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

Depression

9. ___ I feel sad most of the time.
10. ___ I have trouble falling asleep.
11. ___ I wake up frequently after falling asleep.
12. ___ I have difficulty concentrating.
13. ___ I have experienced loss of appetite.
14. ___ I feel tired most of the time.
15. ___ I have lost interest in daily activities

Spirituality:

16. ___ My spirituality helps me cope when I am depressed.
17. ___ I pray when I am depressed.
18. ___ I meditate when I am depressed.
19. ___ I participate in spiritual services when I am depressed.
20. ___ I talk with my pastor when I am depressed.
21. ___ I read the bible when I am depressed.
22. ___ I read daily devotionals when I am depressed.
APPENDIX D

(continued)

Traditional Treatment:

23. ___ When I am depressed I seek professional help.
24. ___ When I am depressed I take anti-depressant medications.
25. ___ When I am depressed I participate in counseling/therapy.
26. ___ When I am depressed I call a crisis line to talk with someone.
27. ___ When I am depressed I exercise.
28. ___ When I am depressed I would write in a journal.
29. ___ When I am depressed I use other homeopathic treatments.

Nontraditional Treatment:

30. ___ When I am depressed I use home remedies.
31. ___ When I am depressed I talk to a close friend.
32. ___ When I am depressed I drink alcohol.
33. ___ When I am depressed I shop.
34. ___ When I am depressed I go out (parties, movies, etc)
35. ___ When I am depressed I eat.
36. ___ When I am depressed I sleep.
APPENDIX E

SPSS Program Analysis

TITLE 'DEPRESSION, SPIRITUALITY AND TREATMENT'.
SUBTITLE 'VICKIE JESTER SCHOOL OF SOCIAL WORK PHD PROGRAM'.

DATA LIST FIXED/
   ID        1-3
   GENDER    4
   ETHNIC    5
   AGEGRP    6
   MARITAL   7
   EMPLOY    8
   EDUC      9
   INCOME    10
   INSURE    11
   DEPRES1   12
   DEPRES2   13
   DEPRES3   14
   DEPRES4   15
   DEPRES5   16
   DEPRES6   17
   DEPRES7   18
   SPIRIT1   19
   SPIRIT2   20
   SPIRIT3   21
   SPIRIT4   22
   SPIRIT5   23
   SPIRIT6   24
   SPIRIT7   25
   TRADTX1   26
   TRADTX2   27
   TRADTX3   28
   TRADTX4   29
   TRADTX5   30
   TRADTX6   31
   TRADTX7   32
   NCTRND1   33
   NCTRND2   34
   NCTRND3   35
   NCTRND4   36
   NCTRND5   37
   NCTRND6   38
   NCTRND7   39.
APPENDIX E

(continued)

VARIABLE LABELS
ID 'Questionnaire Number'
GENDER 'Q1 What is your gender'
ETHNIC 'Q2 Which of the following best describes your Ethnicity'
AGEGRP 'Q3 Which of the following best describes your age group'
MARITAL 'Q4 Which of the following best describes your marital status'
EMPLOY 'Q5 Which of the following best describes your current employment status'
EDUC 'Q6 What is the highest level of education you completed'
INCOME 'Q7 What is your yearly household income'
INSURE 'Q8 Do you have health insurance'
DEPRES1 'Q9 I feel sad most of the time'
DEPRES2 'Q10 I have trouble falling asleep'
DEPRES3 'Q11 I wake up frequently after falling asleep'
DEPRES4 'Q12 I have difficulty concentrating'
DEPRES5 'Q13 I have experienced loss of appetite'
DEPRES6 'Q14 I feel tired most of the time'
DEPRES7 'Q15 I have lost interest in daily activities'
SPIRIT1 'Q16 My spirituality helps me cope when I am depressed'
SPIRIT2 'Q17 I pray when I am depressed'
SPIRIT3 'Q18 I meditate when I am depressed'
SPIRIT4 'Q19 I participate in spiritual services when I am depressed'
SPIRIT5 'Q20 I talk with my pastor when I am depressed'
SPIRIT6 'Q21 I read the bible when I am depressed'
SPIRIT7 'Q22 I read daily devotionals when I am depressed'
TRADTX1 'Q23 When I am depressed I seek professional help'
TRADTX2 'Q24 When I am depressed I take anti-depressant medications'
TRADTX3 'Q25 When I am depressed I participate in counseling-therapy'
TRADTX4 'Q26 When I am depressed I call a crisis line to talk with someone'
TRADTX5 'Q27 When I am depressed I exercise'
TRADTX6 'Q28 When I am depressed I would write in a journal'
TRADTX7 'Q29 When I am depressed I use other homeopathic treatments'
NONTRD1 'Q30 When I am depressed I use home remedies'
NONTRD2 'Q31 When I am depressed I talk to a close friend'
NONTRD3 'Q32 When I am depressed I drink alcohol'
NONTRD4 'Q33 When I am depressed I shop'
NONTRD5 'Q34 When I am depressed I go out - parties, movies etc'
NONTRD6 'Q35 When I am depressed I eat'
NONTRD7 'Q36 When I am depressed I sleep'.

VALUE LABELS
GENDER
1 'Male'
2 'Female'
APPENDIX E
(continued)

ETHNIC
1 'Caucasian'
2 'African American'
3 'Asian American'
4 'Hispanic'
5 'Native American'
6 'Other'/

AGEGRP
1 '19—29'
2 '30—39'
3 '40—49'
4 '50—59'
5 '60—Over'/

MARITAL
1 'Never married'
2 'Married'
3 'Divorced'
4 'Widowed'/

EMPLOY
1 'Full-time'
2 'Part-time'
3 'Homemaker'
4 'Unemployed'
5 'Retired'/

EDUC
1 'Less-high school'
2 'HighSchool grad'
3 'Some college-tech'
4 'College graduate'/

INCOME
1 'Less than $20,000'
2 '$20,000—39,999'
3 '$40,000—59,999'
7 '$60,000—69,999'
8 '$70,000 up'/

INSURE
1 'Yes'
2 'No'/

DEPRESS
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

DEPRESS2
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
APPENDIX E

(continued)

DEPRES3
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

DEPRES4
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

DEPRES5
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

DEPRES6
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

DEPRES7
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

SPIRIT1
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

SPIRIT2
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

SPIRIT3
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

SPIRIT4
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

SPIRIT5
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
APPENDIX E
(continued)

SPIRIT6
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

SPIRIT7
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

TRADTX1
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

TRADTX2
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

TRADTX3
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

TRADTX4
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

TRADTX5
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

TRADTX6
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

TRADTX7
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

NONTRD1
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/
APPENDIX E

(continued)

NONTRD2
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

NONTRD3
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

NONTRD4
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

NONTRD5
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

NONTRD6
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/

NONTRD7
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/.

MISSING VALUES
GENDER ETHNIC AGEGRP MARITAL EMPLOY EDUC INCOME INSURE DEPRES1 DEPRES2 DEPRES3 DEPRES4 DEPRES5 DEPRES6 DEPRES7 SPIRIT1 SPIRIT2 SPIRIT3 SPIRIT4 SPIRIT5 SPIRIT6 SPIRIT7 TRADTX1 TRADTX2 TRADTX3 TRADTX4 TRADTX5 TRADTX6 TRADTX7 NONTRD1 NONTRD2 NONTRD3 NONTRD4 NONTRD5 NONTRD6 NONTRD7 (0).

BEGIN DATA
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APPENDIX E

(continued)

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APPENDIX E

(continued)

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APPENDIX E

(continued)
APPENDIX E

(continued)

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END DATA.
APPENDIX E

(continued)

/FREQUENCIES
/VARIABLES GENDER ETHNIC AGEGRP MARITAL EMPLOY EDUC INCOME INSURE
DEPRES1 DEPRES2 DEPRES3 DEPRES4
DEPRES5 DEPRES6 SPIRIT1 SPIRIT2 SPIRIT3 SPIRIT4 SPIRIT5 SPIRIT6
SPIRIT7 TRADTX1 TRADTX2
TRADTX3 TRADTX4 TRADTX5 TRADTX6 TRADTX7 NONTRD1 NONTRD2 NONTRD3 NONTRD4
NONTRD5 NONTRD6 NONTRD7
/STATISTICS=.
REFERENCES


Bell, C.C. (1979). The need for psychoanalysis is alive and state may be that of being strongly attracted to the well in community psychiatry. *Journal of National Medical Association*, 71, 361-368.


