A study comparing African American men and women with a mental health disorder and their dependency on others

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This current study examines a comparison between African-American men (N=25) and women (N=25) who were diagnosed with a mental disorder and assessed their level of dependency on others. This study suggests that some people with specific mental health disorders have strong emotional and psychosocial attachment to dependency which limits their ability to think and do for themselves. Level of dependency includes emotional reliance on others, low self-confidence, and lack of autonomy.

Findings revealed that men were more dependent on others than women. Also, those diagnosed with Schizophrenia were more dependent on others than those diagnosed with Anxiety, Bipolar or Depression.

As the findings of this study revealed that men with mental disorders were more dependent on others than women, as practitioners it might be beneficial to find gender specific activities, resources and services tailored to men that will help enhance them to become more independent. For the findings by mental disorder, practitioners should
create and implement disorder specific interventions that include activities, resources, and services that will improve the day to day social functioning and activeness of clients.
A STUDY COMPARING AFRICAN-AMERICAN MEN AND WOMEN WITH A MENTAL HEALTH DISORDER AND THEIR DEPENDENCY ON OTHERS

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK

BY
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CHAPTER I
INTRODUCTION

We live in a world where constant interaction with other people occurs daily. This is true among families, friends, neighbors, in schools, on jobs, within intimate relationships, in public settings, on social outings, using public transportation, etc. As an individual, one can choose to live in social isolation with a certain level of independence to do a lot of things without the aid of others.

When a person has a serious mental disorder this could pose a challenge to his or her ability to function independently. As a result, some form of interpersonal dependency on others is most likely to occur.

According to the National Institute of Mental Health (NIMH), mental disorders are common in the United States. An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year. When applied to the 2004 U.S. Census residential population estimate for ages 18 and older, this figure translates to 57.7 million people. Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion — about 6 percent, or 1 in 17 — who suffer from a serious mental illness (NIMH, 2010).

NIMH (2010) reports mental disorders are the leading cause of disability in the U.S. and Canada. Many people suffer from more than one mental disorder at a given
time. Nearly half (45 percent) of those with any mental disorder meet criteria for 2 or more disorders, with severity strongly related to comorbidity.

There are four common mental disorders that challenges independent living; Anxiety, Bipolar, Major Depression, and Schizophrenia. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) published by the American Psychiatric Association (2000) provides a detailed description of the criteria that clinically diagnoses a person with each disorder. According to the DSM-IV, the four disorders fall under Axis I.

NIMH (2010) provides definitions, statistics, symptoms, and other useful information for each specific mental disorder. For anxiety, it is a normal reaction to stress. It helps one deal with a tense situation in the office, study harder for an exam, and keep focused on an important speech. In general, it helps one cope. But when anxiety becomes an excessive, irrational dread of everyday situations, it has become a disabling disorder.

There are five major types of anxiety disorders: Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Panic Disorder, Post-Traumatic Stress Disorder, and Social Anxiety Disorder.

Generalized Anxiety Disorder

Generalized Anxiety Disorder, GAD, is an anxiety disorder characterized by chronic anxiety, exaggerated worry and tension, even when there is little or nothing to provoke it. People with generalized anxiety disorder can't seem to shake their concerns. Their worries are accompanied by physical symptoms, especially fatigue, headaches, muscle tension, muscle aches, difficulty swallowing, trembling, twitching, irritability, sweating, and hot flashes (NIMH, 2010).
Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder, OCD, is an anxiety disorder and is characterized by recurrent, unwanted thoughts (obsessions) and/or repetitive behaviors (compulsions). Repetitive behaviors such as hand washing, counting, checking, or cleaning are often performed with the hope of preventing obsessive thoughts or making them go away. Performing these so-called "rituals," however, provides only temporary relief, and not performing them markedly increases anxiety. People with OCD may be plagued by persistent, unwelcome thoughts or images, or by the urgent need to engage in certain rituals. They may be obsessed with germs or dirt, and wash their hands over and over. They may be filled with doubt and feel the need to check things repeatedly (NIMH, 2010).

Panic Disorder

Panic Disorder is an anxiety disorder and is characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, shortness of breath, dizziness, or abdominal distress. People with panic disorder have feelings of terror that strike suddenly and repeatedly with no warning. During a panic attack, most likely the heart will pound and it may feel sweaty, weak, faint, or dizzy. A person’s hands may tingle or feel numb, and might feel flushed or chilled. The person may have nausea, chest pain or smothering sensations, a sense of unreality, or fear of impending doom or loss of control (NIMH, 2010).

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder, PTSD, is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or
was threatened. Traumatic events that may trigger PTSD include violent personal
assaults, natural or human-caused disasters, accidents, or military combat. People with
PTSD have persistent frightening thoughts and memories of their ordeal and feel
emotionally numb, especially with people they were once close to. They may experience
sleep problems, feel detached or numb, or be easily startled (NIMH, 2010).

Social Phobia or Social Anxiety Disorder

Social Phobia, or Social Anxiety Disorder, is an anxiety disorder characterized by
overwhelming anxiety and excessive self-consciousness in everyday social situations.
Social phobia can be limited to only one type of situation — such as a fear of speaking in
formal or informal situations, or eating or drinking in front of others — or, in its most
severe form, may be so broad that a person experiences symptoms almost anytime they
are around other people. People with social phobia have a persistent, intense, and chronic
fear of being watched and judged by others and being embarrassed or humiliated by their
own actions. Their fear may be so severe that it interferes with work or school, and other
ordinary activities. Physical symptoms often accompany the intense anxiety of social
phobia and include blushing, profuse sweating, trembling, nausea, and difficulty talking
(NIMH, 2010).

NIMH (2004) reports approximately 40 million American adults ages 18 and
older, or about 18.1 percent of people in this age group in a given year, have an anxiety
disorder. Anxiety disorders frequently co-occur with depressive disorders or substance
abuse. Most people with one anxiety disorder also have another anxiety disorder. Nearly
three-quarters of those with an anxiety disorder will have their first episode by age 21.5.
Bipolar disorder

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. Symptoms of Bipolar disorder are severe. They are different from the normal ups and downs that everyone goes through from time to time. Bipolar disorder symptoms can result in damaged relationships, poor job or school performance, and even suicide. But Bipolar disorder can be treated, and people with this illness can lead full and productive lives. Bipolar disorder often develops in a person's late teens or early adult years. At least half of all cases start before age 25. Some people have their first symptoms during childhood, while others may develop symptoms late in life (NIMH, 2010).

NIMH (2004) reports Bipolar disorder affects approximately 5.7 million American adults, or about 2.6 percent of the U.S. population age 18 and older in a given year. The median age of onset for bipolar disorders is 25 years.

Major Depressive Disorder

A depressive disorder is an illness that involves the body, mood, and thoughts. It affects the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things. A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better. Without treatment, symptoms can last for weeks, months, or years. Appropriate treatment, however, can help most people who suffer from depression (NIMH, 2008).

NIMH (2004) reports Major Depressive Disorder is the leading cause of disability in the U.S. for ages 15-44. Major depressive disorder affects approximately 14.8 million
American adults, or about 6.7 percent of the U.S. population age 18 and older in a given year. While major depressive disorder can develop at any age, the median age at onset is 32. Major depressive disorder is more prevalent in women than in men.

Schizophrenia disorder

Schizophrenia is a chronic, severe, and disabling brain disorder that has affected people throughout history. About 1 percent of Americans have this illness. People with the disorder may hear voices other people don't hear. They may believe other people are reading their minds, controlling their thoughts, or plotting to harm them. This can terrify people with the illness and make them withdrawn or extremely agitated. People with Schizophrenia may not make sense when they talk. They may sit for hours without moving or talking. Sometimes people with Schizophrenia seem perfectly fine until they talk about what they are really thinking. Families and society are affected by Schizophrenia too. Many people with schizophrenia have difficulty holding a job or caring for themselves so, they rely on others for help. Treatment helps relieve many symptoms of Schizophrenia, but most people who have the disorder cope with symptoms throughout their lives. However, many people with Schizophrenia can lead rewarding and meaningful lives in their communities. Researchers are developing more effective medications and using new research tools to understand the causes of Schizophrenia. In the years to come, this work may help prevent and better treat the illness (NIMH, 2010).

NIMH (2004) reports approximately 2.4 million American adults, or about 1.1 percent of the population age 18 and older in a given year, have Schizophrenia. Schizophrenia affects men and women with equal frequency. Schizophrenia often first
appears in men in their late teens or early twenties. In contrast, women are generally affected in their twenties or early thirties.

Statement of the Problem

For the men and women that live day to day with a mental health disorder their ability to function independently can greatly be impacted to the point where they may have the tendency to depend on others for assistance. This statement poses several questions which should be researched. Are people diagnosed with mental health disorders getting the needed support from others with the goal of enhancing their ability to function independently? Also, is there a significant level of dependency on their behalf to truly rely on others or is there a greater level of independence to do for themselves?

The American Psychiatric Association (2010) reports according to NIHM, African-Americans and other diverse communities are underserved by the nation’s mental health system. For example, one out of three African-Americans who need mental health care receives it. This is important to know because being underserved by the mental health system has led African-Americans to find other means of support that may add to why some develop dependency relationships on others to intervene on their behalf.

NIMH (2004) adds that often times African-Americans turn to family, church and community to cope. The level of religious commitment among African-Americans is high. In one study, approximately 85 percent of African-Americans respondents described themselves as “fairly religious” or “religious” and prayer was among the most common way of coping with stress.

Because African-Americans often turn to community — family, friends, neighbors, community groups and religious leaders — for help, the opportunity exists for community
health services to collaborate with local churches and community groups to provide mental health care and education to families and individuals. Studies have shown that family participation in a support group or a church group can improve the family’s ability to care for family members with mental disorders and cope with the emotional distress of being a caregiver (NIMH, 2004).

Purpose of the Study

This study will focus on interpersonal relationships by exploring a targeted group of African-American men and women with a confirmed mental health diagnosis to access their level of dependency on other people versus their level of independency to do for self.

The purpose of this study is to identify by gender and by specific mental disorders those who have the greater level of dependency on others. The level of dependency among those with mental health disorders is measured by their emotional reliance on others, their lack of self-confidence, and their level of autonomy.

The independent variable is described as the dependency in the areas of emotional reliance, lack of self-confidence, and assertion of autonomy. The dependent variables are characterized as men and women with a mental health disorder.
Research Question and Hypothesis

Research Question: Do men diagnosed with a mental disorder depend more on others than women with a mental health disorder?

Null hypothesis: There is a difference between men with a mental disorder being dependent on others than women with a mental disorder.

Alternative hypothesis: There is no difference between men with a mental disorder being dependent on others than women with a mental disorder.

Significance of the Study

This study compares African-American men and women with mental health disorders and their level of dependency on others to function from day to day. The expectation is to find a certain level of independency among the participants being studied. In doing so, new strategies and interventions can be implemented to address and enhance those diagnosed with a mental disorder to live safe and hopefully more independently.

By measuring Anxiety Disorder, Bipolar Disorder, Depression and Schizophrenia, the study is mainly expected to reveal which particular disorder and which gender has the greater level of dependency. The goal is to eventually create and implement effective treatment plans to motivate and empower the most dependent clients to become more self-sufficient and dependent on themselves.
CHAPTER II

REVIEW OF LITERATURE

Definitions of Specific Terms in the Literature

*Anaclitic* – a form of dependency, such as that experienced by an infant for its caregiver (Social Work Dictionary, 2003).

*Autonomy* – an individual’s sense of being capable of independent action; the ability to provide for one’s own need (Social Work Dictionary, 2003).

*Emotional Dependency* – (same as emotional reliance) is defined as an emotional need manifested by a marked and habitual inclination to rely on another for comfort, support, guidance, and decision making; the tendency to seek help from others in making decisions or in carrying out difficult actions; the need to be mothered, loved, taken care of, emotionally supported. In extreme cases such persons lose their ability to function independently (Farlex, Inc., 2008).

*Independence* – the capability of an individual to be self-governing and not dependent on others for care, well-being, or livelihood (Social Work Dictionary, 2003).

*Introjective* – a mental mechanism in which the individual derives feelings from another person or object and directs them internally to an imagined form of the person or object (Social Work Dictionary, 2003).

*Nurturant* – behaviors and activities that further the growth and development of another person, family, group, or community (Social Work Dictionary, 2003).
Self Confidence - is an attitude which allows individuals to have a positive yet realistic view of themselves and their situations. Self-confident people trust their own abilities, have a general sense of control in their lives, and believe that, within reason, they will be able to do what they wish, plan, and expect (Psychology Wiki, 2010).

Sociotropy - is characterized as an excessive investment in interpersonal relationships (Beck, 1983).

Unipolar Depression - an affective disorder manifested by either a dysphoric mood or loss of interest or pleasure in usual activities. The mood disturbance is prominent and relatively persistent (Online Medical Dictionary, 2010).

Historical Perspective

According to Jackson (2002), African-Americans have a presence in America dating back to at least 1619 when the first African indentured servants arrived in America. One of the earliest records dealing with the issue of insanity among African-Americans was in 1745 when the South Carolina Colonial assembly took up the case of Kate, a slave woman, who had been accused of killing a child. After being placed in the local jail, it was determined that Kate was "out of her senses" and she was not brought to trial. However, the problem of how to care for Kate was an issue since her owner was too poor to pay for her confinement and South Carolina had made no provision for the public maintenance of slaves. Ultimately, the colonial assembly passed an act that made each parish in the colony responsible for the public maintenance of lunatic slaves whose owners were unable to care for. Not surprisingly, there is no further record of what happened to Kate or what circumstances led to the murder of the child.
In 1851, Dr. Samuel Cartwright, a prominent Louisiana physician and one of the leading authorities in his time on the medical care of Negroes, identified two mental disorders peculiar to slaves. *Drapetomia*, or the disease causing Negroes to run away, was noted as a condition, "unknown to our medical authorities, although its diagnostic symptom, the absconding from service, is well known to our planters and overseers." Dr. Cartwright observed, "The cause in most cases, that induces the Negro to run away from service, is such a disease of the mind as in any other species of alienation, and much more curable, as a general rule." Cartwright was so helpful as to identify preventive measures for dealing with potential cases of drapetomania. Slaves showing incipient drapetomania, reflected in sulky and dissatisfied behavior should be whipped strictly as a therapeutic early intervention. Planter and overseers were encouraged to utilize whipping as the primary intervention once the disease had progressed to the stage of actually running away. Overall, Cartwright suggested that Negroes should be kept in a submissive state and treated like children, with "care, kindness, attention and humanity, to prevent and cure them from running away" (Jackson, 2002)

Dr. Cartwright also diagnosed *Dysaesthesia Aethiopica*, or "hebetude of the mind and obtuse sensibility of the body which is a disease peculiar to Negroes called by overseers as rascality." Dysaesthesia Aethiopica differed from other species of mental disease since physical signs and lesions accompanied it. The ever-resourceful Dr. Cartwright determined that whipping could also cure this disorder. Of course, one wonders if the whipping were not the cause of the "lesions" that confirmed the diagnosis (Jackson, 2002).
Not surprisingly, Dr. Cartwright was a leading thinker in the pro-slavery movement. Dr. Cartwright, in his article "Diseases and Peculiarities of the Negro Race," chided his anti-slavery colleagues by noting:

"The northern physicians and people have noticed the symptoms, but not the disease from which they spring. They ignorantly attribute the symptoms to the debasing influence of slavery on the mind without considering that those who have never been in slavery, or their fathers before them, are the most afflicted, and the latest from the slave-holding south the least. The disease is the natural offspring of Negro liberty which is the liberty to be idle, to wallow in filth, and to indulge in improper food and drinks" (Jackson, 2002).

African-Americans were frequently housed in public (as opposed to private) facilities such as the poorhouse, jail or the insane asylum. These facilities almost always had substandard conditions. If conditions in the facility were poor for white patients, conditions were completely inhumane for African-American patients. For instance, one of the first patients admitted to the South Carolina Lunatic Asylum in 1829 was a fourteen-year-old slave named Jefferson. Jefferson's name was not recorded in the admission book and he was reportedly housed in the yard. The young slave was admitted as a favor to his owner since the facility did not officially receive blacks (Jackson, 2002).

The issue of housing black and white mental patients in the same facility was a struggle in both Northern and Southern States since many leading mental health experts felt that it undermined the mental health of white patients to be housed with African-Americans. The distress of having black and white patients in close proximity to one
another was balanced by the unwillingness to fund segregated facilities for black patients (Jackson, 2002).

Anxiety Disorders and Dependency on Others

Sato, McCann, and Ferguson-Isaac (2004) reported that sociotropy and autonomy are conceptualized as two personality dimensions that relate to individuals' vulnerability to anxiety and depression. Sociotropy is characterized as an excessive investment in interpersonal relationships, and autonomy is characterized as an excessive concern with independence as well as a lack of concern for others. Their study investigated the relationships between sociotropy-autonomy and trait anxiety associated with four types of situations, i.e., Social Evaluation, Physical Danger, Ambiguous Situation, and Daily Routine. Two hundred and fifty-five undergraduate students completed the Sociotropy-Autonomy Scale, the Endler Multidimensional Anxiety Scale, and the Beck Depression Inventory. Analyses indicated that scores on Sociotropy were positively correlated with rated trait anxiety in situations of Social Evaluation, Physical Danger, and Ambiguous Situations, whereas scores on Autonomy were positively correlated with rated trait anxiety in Daily Routines.

Sato and McCann (2007) reported that sociotropy and autonomy are conceptualized as two personality dimensions that relate to an individual's vulnerability to depression. Sociotropy is characterized as an excessive investment in interpersonal relationships, and autonomy is characterized as an excessive concern with personal achievement and control. Their study examined the relationships between sociotropy and autonomy, and a variety of interpersonal problems with close and nonclose others.
Results suggested that sociotropic individuals are overly nurturant to nonclose others but vindictive to individuals who are close to them. In contrast, autonomous individuals were found to be domineering to nonclose others but socially avoidant toward people close to them.

Zaider, Heimberg, and Iida (2010) reported that although adults with anxiety disorders often report interpersonal distress, the degree to which anxiety is linked to the quality of close relationships remains unclear. The authors examined the relational impact of anxiety by sampling the daily mood and relationship quality of 33 couples in which the wife was diagnosed with an anxiety disorder. Use of a daily process design improved on prior methodologies by capturing relational processes closer to their actual occurrence and in the setting of the diagnosed partner’s anxiety. Analyses revealed significant associations between wives’ daily anxiety and both partners’ perceptions of relationship quality. Associations were moderated by anxiety-specific support. Results also indicated significant concordance between wives’ daily anxiety and husbands’ distress. Concordance was stronger for husbands who reported frequent accommodation of wives’ anxiety symptoms.

Social phobia is classified as an anxiety disorder in psychiatric nomenclature. It represents a fear of performance or social interaction that significantly interferes with a person’s social or occupational functioning. The author takes issue with the fact that social phobia is considered by many professionals to be a mental illness that is often treated best with medication. Social phobia can be conceptualized from a social work perspective as an extreme shyness that can be overcome with cognitive learning and
behavioral rehearsal. This article reviews the biopsychosocial causes of social phobia and presents a summary of cognitive and behavioral interventions with empirically demonstrated effectiveness (Walsh, 2002).

Anxiety Disorders Significant Among African-Americans

Phobias. Anxiety disorders are relatively common worldwide, affecting approximately 16.6% of the global population. Only recently, however, have researchers attempted to study anxiety disorders by population. Here is some information on the prevalence of agoraphobia and social phobia in varying groups of people (Fritscher, 2008).

Agoraphobia is difficult to study by analyzing previous research, as for many years agoraphobia was considered a diagnosis completely separate from panic disorder. When the DSM-III-R (Diagnostic and Statistical Manual, 3rd Ed., Revised) was released, agoraphobia became a secondary disorder and was connected to panic disorder. In the current DSM-IV (Diagnostic and Statistical Manual, 4th Ed.), agoraphobia is considered a separate condition only if the criteria are not met for panic disorder. Nonetheless, some information on the prevalence of agoraphobia can be deduced. Agoraphobia appears to be much more prevalent in women than in men across every age group. The condition is also much more common in African-Americans than in either whites or Hispanics. Agoraphobia also appears to be more prevalent in lower income brackets and those who are not employed outside of the home (Fritscher, 2008).

Lifetime rates of social phobia vary dramatically between countries. It is estimated that approximately 45.6% of the population of Udmurtia, Udmurt Republic
(part of the Russian Federation) suffers from social phobia. On average, however, approximately 3.6% of the world population experiences social phobia. Also, social phobia is much more prevalent among women than men. Rates are higher among younger adults (those under age 30) and students. Social phobia appears to be more prevalent among those with lower incomes and less education (Fritscher, 2008).

Obsessive-Compulsive Disorder (OCD). Great strides have been made in developing effective treatments for people with obsessive-compulsive disorder (OCD), but not all segments of our society have benefited. African-Americans experience OCD at similar rates as the general population, but are less likely to receive treatment. Among those with severe OCD, 93% of Americans receive some type of treatment but only 60% for African-Americans do. Even among those who are able to access care, few African-Americans receive specialized treatment, and only 20% are using an SRI medication, the most effective medication for OCD (Williams, 2010).

The DSM-IV field trial, one of the largest studies of Americans with OCD, was devised to better understand the symptoms of OCD. The study examined patients at top OCD specialty clinics at five urban sites. However, out of 454 participants, only 2.8% were African-Americans, whereas 94.6% were European-Americans. The absence of African-Americans being assessed or treated at these specialty clinics supports the finding that black people are less likely to receive the most effective treatments for OCD. As a result, African-Americans are more likely to experience lifelong disability from this treatable disorder (Williams, 2010).
African-Americans are absent in OCD specialty clinics and are also under-represented in research studies. In the scientific literature, there are almost no published studies focused on the diagnosis, assessment, or treatment of African-Americans who have OCD. Thus, there is much we do not know about the treatment of African-Americans with OCD, using medication or psychological therapy. The small amount of work that has been done examining African-Americans with OCD has found some striking differences from European-Americans. For example, black Americans were more likely to have a later age of onset (32 years), as opposed to late adolescence (19 years). Later age of onset is associated with greater severity, poorer insight, and a higher chance of having other disorders. Once black patients meet criteria for OCD, they were very unlikely to get better, leading top scientists to conclude that high levels of overall mental illness comorbidity and severity, limited access to state-of-the-art treatments, or reduced responses to currently available OCD treatments, which have not been well tested in the African-American population, may all contribute to the high OCD persistence (Williams, 2010).

Post Traumatic Stress Disorder (PTSD). Researchers have conducted various studies of PTSD in ethnic minority Vietnam Veteran populations. The results of the studies are not entirely consistent, but the overall finding seems to be that most ethnic minority Veteran groups have a higher rate of PTSD than White Veterans. Some of this may be due to psychological conflicts related to identification with the Vietnamese. Another factor may be higher exposure to war zone stressors (Loo, 2007).
The National Vietnam Veterans Readjustment Study found differences among Hispanic, African-American, and white Vietnam Veterans in terms of readjustment after military service. Both Hispanic and African-American male Vietnam Veterans had higher rates of PTSD than whites. Rates of current PTSD in the 1990 study were 28% among Hispanics, 21% among African-Americans, and 14% among whites (Loo, 2007).

African-Americans had greater exposure to war stresses and had more predisposing factors than whites, which appeared to account for their higher rate of PTSD. After controlling for these factors, the differences in PTSD rates between whites and African-Americans largely disappeared. On the other hand, the difference in rates of PTSD between Hispanics and whites remained even after controlling for the fact that Hispanics had greater exposure to war stresses (Loo, 2007).

Himle, Baser, Taylor, Campbell, and Jackson (2009) conducted a study to estimate prevalence, ages of onset, severity, and associated disability of anxiety disorders among African-Americans, Caribbean Blacks, and non-Hispanic whites in the U.S. Results indicated that whites were at elevated risk for generalized anxiety disorder, panic disorder, and social anxiety compared to Caribbean Blacks and African-Americans. Black respondents were more likely to meet criteria for PTSD. When African-American and Caribbean Black respondents met criteria for an anxiety disorder, they experienced higher levels of overall mental illness severity and functional impairment compared to whites. White respondents were at greater risk to develop generalized anxiety, social anxiety, and panic disorders late in life. Risk of developing PTSD endured throughout the life course for blacks whereas whites rarely developed PTSD after young adulthood.
These results can be used to inform targeted interventions to prevent or remediate anxiety disorders among these diverse groups.

Bipolar Disorder and Dependency on Others

Hammen, Ellicott, Gitlin, and Jamison (1989) followed samples of unipolar and bipolar patients for a 6-month period, with independent assessment of symptoms and life events. Patients were initially categorized into subtypes using Beck's Sociotropy/Autonomy Scale (1983), with the prediction that onset or exacerbation of symptoms, as well as more total symptoms, would occur for sociotropic individuals experiencing more negative interpersonal events than achievement events, and for autonomous-achievement patients experiencing more achievement events than interpersonal events. Results were confirmed for unipolars, indicating that the course of disorder was associated with the occurrence of personally meaningful life events, but not for bipolars. Further research is recommended to examine whether the effect is equally robust for both subtypes of unipolars, whether longer study duration may be required for bipolars, and whether a cognitive self-schema mechanism may account for the specific vulnerability to a subset of stressful events.

McDavid and Thase (1995) report our sense of personal and physical integrity is undermined by chronic illness. The fragility and temporality of life is intimated, and the inviolability of the body and the belief in our autonomy is threatened. Manic depression, or bipolar affective disorder, is a chronic illness that displays a highly variable course and generally manifests in the second or third decade of life. Perhaps more prominently than other chronic medical illnesses, people with manic depression are perplexed by whether
they have engendered the illness and whether it is an integral part of their personality, temperament, or nature. This disquieting ambiguity can be difficult to resolve, and often has a profound emotional impact.

McDavid and Thase (2010) reported that people with Bipolar Affective disorder do not experience their episodes of illness in a vacuum and, as a result, family, friends, and colleagues invariably bear some of the disruption, too, often with great distress. Attention to occupational, social, family, and interpersonal problems and ethical or legal difficulties is critical in maintaining long term progress. They found that it is best to involve the family or significant others in the treatment alliance, without, of course, compromising the confidentiality of the doctor patient relationship.

Bipolar Disorders Significant Among African-Americans

Mental Health America (2010) reported an estimated 2.3 million Americans have Bipolar disorder, also called manic-depressive illness. A person with Bipolar disorder can go from feeling very, very high (called mania) to feeling very, very low (depression). With proper treatment, people can control these mood swings and lead fulfilling lives. While the rate of Bipolar disorder is the same among African-Americans as it is among other Americans, African-Americans are less likely to receive a diagnosis and, therefore, treatment for this illness. Most African-Americans with Bipolar disorder are going undiagnosed and untreated.

MHA listed several factors that have contributed to African-Americans not receiving help for Bipolar disorder and other mental illnesses. Some of the reasons are:
• A mistrust of health professionals, based in part on historically higher-than-average institutionalization of African-Americans with mental illness; and on previous mistreatments, like such tragic events as the Tuskegee syphilis study.

• Cultural barriers between many doctors and their patients.

• Reliance on the family and religious community, rather than mental health professionals, during times of emotional distress.

• A tendency to talk about physical problems, rather than discuss mental symptoms, or to mask symptoms with substance abuse or other medical conditions.

• Socioeconomic factors which can limit access to medical and mental health care.

• About 25 percent of African-Americans do not have health insurance.

• Continued misunderstanding and stigma about mental illness.

Depression Disorder and Dependency on Others

Newman, Gray, and Choi (2009) conducted researched using Aaron Beck's Sociotropy-Autonomy Scale to study sociotropy, autonomy, and masculinity/femininity to access vulnerability to depression with six measures of sex-role orientation using a convenience sample of one hundred and fifty-three undergraduate students. The sample included ninety-five women and fifty-eight men whose mean age was 20.4 yr. A principal axis factor analysis yielded two factors, one masculine and one feminine. Sociotropy related strongly to the feminine factor, and Autonomy related strongly to the masculine factor. The mean score for women was significantly higher than that for men on Sociotropy, but the mean difference on Autonomy was not statistically significant.
These findings suggest there may be some definitional overlap between vulnerability to depression and sex-role orientation.

Robins, Block, and Peselow (1989) researched the relationship of sociotropic and autonomous personality characteristics to specific symptoms in depressed patients. They examined the relations between levels of sociotropic and autonomous personality characteristics and specific, theoretically derived clusters of symptoms in 80 unipolar depressed patients. As was predicted, sociotropy was related to the cluster of symptoms associated with the concept of anxious-reactive depression and was unrelated to the autonomous symptoms cluster. In contrast, the predicted relations of autonomous personality characteristics and symptoms were not found. These results support the idea that the symptom picture in depression may be related to personality characteristics, but they also suggest that the measurement of autonomy may require revision.

Klein, Harding, Taylor, and Dickstein (1988) explored dependency and self-criticism in depression in a clinical population using Sidney Blatt's (1974) model of depression. Subjects included sixty-three female outpatients with major depression and fifteen women with no lifetime history of psychopathology. All subjects received structured diagnostic and family history interviews and completed the Depressive Experiences Questionnaire (DEQ), which was developed to assess Blatt's concepts of analytic and introjective depression. In addition, the depressives received extensive follow-up assessments 6 months later. The depressives had significantly higher levels of analytic and introjective traits, respectively. Dependency and, to a lesser extent, self-criticism appeared to be influenced by clinical state, as recovered depressives' scores
exhibited a greater decline between the initial and follow-up assessments than did
nonrecovered patients' scores. Finally, analyses examining the relation between
dependency and self-criticism and a broad range of clinical, family history, and short-
term outcome variables provided little support for Blatt's (1974) model.

McBride and Bagby (2006) studied rumination and interpersonal dependency to
explain women's vulnerability to depression. They found that women are twice as likely
as men to suffer from a major depressive episode. Reasons for this gender difference in
propensity for depression are not completely understood, although a number of
explanations have been articulated. In their study they focused on two constructs that
have been linked to gender differences in depression—ruminative cognitive style and
interpersonal dependency. Ruminative cognitive style refers to the tendency to respond to
depressed or dysphoric mood with repetitive thoughts and behaviors that focus attention
Interpersonal dependency reflects an investment in relationships and communion. They
propose a theory of how these constructs interact to increase women's propensity to
develop depression.

Steger and Kashdan (2009) researched people with depression in relationship to
everyday social activity, belonging, and well-being. They found that dysfunctional social
behavior has been implicated in the experience of depression. People with greater
depressive symptoms report more frequent negative social interactions and react more
strongly to them. It remains unknown, however, whether reaction strength differs
depending on whether social interactions are positive or negative. Drawing on socio-
evolutionary models of depression (Allen and Badcock, 2003), proposed that people with greater depressive symptoms should not only react more strongly to negative social interactions but also to positive social interactions and a sense of belonging. Using non-clinical samples, two daily process studies examined the role of depression in people's reactivity to social interactions in natural, ongoing, social contexts. In Study 1, the number of positive and negative social events showed a stronger relation to well-being among people with greater depressive symptoms. Study 2 extended this finding to perceptions of belonging in memorable social interactions, finding a stronger link between belonging and well-being among people with greater depressive symptoms. Together these studies provide the first indication that depressive symptoms may sensitize people to everyday experiences of both social rejection and social acceptance.

Depression Significant Among African-Americans

Mental Health America (2010) reports that anyone can experience clinical depression, regardless of race, gender, age, creed or income. Every year more than 19 million Americans suffer from some type of depressive illness. MHA reports African-Americans are over-represented in populations that are particularly at risk for mental illness. Depression robs people of the enjoyment found in daily life and can even lead to suicide. A common myth about depression is that it is “normal” for certain people to feel depressed—older people, teenagers, new mothers, menopausal women, or those with a chronic illness. The truth is that depression is not a normal part of life for any African American, regardless of age or life situation. Unfortunately, depression has often been misdiagnosed in the African American community.
MHA discussed some of the myths and stigma that surround depression that created needless pain and confusion, and can keep people from getting proper treatment. The following statements reflect some common misconceptions about African-Americans and depression:

"Why are you depressed? If our people could make it through slavery, we can make it through anything." "When a black woman suffers from a mental disorder, the opinion is that she is weak. And weakness in black women is intolerable."

"You should take your troubles to Jesus, not some stranger/psychiatrist."

The truth is that getting help is a sign of strength. People with depression can't just "snap out of it." Also, spiritual support can be an important part of healing, but the care of a qualified mental health professional is essential. And the earlier treatment begins the more effective it can be.

Schizophrenia Disorder and Dependency on Others

Morse, Robins, and Gittes-Fox (2002) report sociotropy and autonomy (Beck, 1983) are sets of beliefs, concerns, and behavioral tendencies that are proposed to create vulnerability to depression and other psychopathology and to influence its manifestation and treatment response. Blatt (1974) made similar suggestions. He investigated the differential relations of sociotropy and autonomy to dimensional scores for each DSM-III-R personality disorder (PD) in a sample of one hundred eighty-eight psychiatric patients, controlling for the other set of characteristics and for the other PDs. Histrionic and dependent PD traits were related specifically to sociotropy. Paranoid, schizoid, schizotypal, and passive-aggressive PD traits were related specifically to autonomy.
Borderline, narcissistic, avoidant, and self-defeating PD traits were related significantly and about equally to both sociotropy and autonomy. Obsessive-compulsive PD traits were not related consistently to either. Results suggest that sociotropy and autonomy may be useful constructs for understanding and treating PDs.

McGlashan and Bardenstein (1990) examined gender differences in the clinical profiles and long-term outcomes of chronic DSM-III Axis I psychotic inpatients from the Chestnut Lodge follow up study. Diagnostic groups include schizophrenia, schizoaffective psychosis, and unipolar affective disorder. Sex differences were frequent, especially in schizophrenia. Females with schizophrenia, for example, had superior premorbid social, sexual, and marital adjustments. They presented at index hospitalization with more depression, self-destructive behaviors, and troubled interpersonal relationships. Their long-term outcomes were better than males in terms of social activity, work competence, time symptomatic, substance abuse, and marital and parental status. Baseline gender differences were comparatively sparse for the schizoaffective and unipolar cohorts. Outcome differences were virtually nonexistent among the schizoaffective patients but unipolar females received better ratings than males in work competence and substance abuse. Females had a later onset of illness and males presented with more antisocial behaviors across all three diagnostic groups. Results highlight the importance of analyzing data by gender in studies of the psychotic disorders.

Guada, Brekke, Floyd, and Barbour (2009) examined whether Perceived Criticism (PC) was related to community functioning in a sample of African-American consumers
with Schizophrenia. The study tested assumptions from the Expressed Emotion literature that were based primarily on samples of white consumers. The study found that PC affected psychiatric symptomatology but not psychosocial functioning. Greater family contact was strongly related to better psychosocial functioning. Findings suggested that the nature and impact of contact between consumer and family for this sample of African-Americans appears different from what has been found in white, middle-class samples.

Schizophrenia Significant Among African-Americans

Harrison (2008) reported that researchers have identified a number of different risk factors and risk-minimizing factors that relate to the frequency of Schizophrenia among different groups of people. Being African American was once considered a risk factor, because African-Americans are 1.5 times more likely than white Americans to develop Schizophrenia. However, that effect is due to the greater numbers of African-Americans living in cities, and is not true when all people living in the country are considered.

National Alliance on Mental Health (2010) reported that African-Americans in the United States are less likely to receive accurate diagnoses than their Caucasian counterparts. Schizophrenia, for instance has been shown to be over diagnosed in the African-American population. Culture biases against mental health professionals and health care professionals in general prevent many African-Americans from accessing care due to prior experiences with historical misdiagnoses, inadequate treatment and a lack of cultural understanding; only 2 percent of psychiatrists, 2 percent of psychologists and 4
percent of social workers in the United States are African American. African-Americans tend to rely on family, religious and social communities for emotional support rather than turning to health care professionals, even though this may at times be necessary. The health care providers they seek may not be aware of this important aspect of person life. Mental illness is frequently stigmatized and misunderstood in the African-American community. African-Americans are much more likely to seek help though their primary care doctors as opposed to accessing specialty care. African-Americans are often at a socioeconomic disadvantage in terms of accessing both medical and mental health care: in 2006, one-third of working adult African-Americans was uninsured in the preceding year. Experiences of mental illness vary across cultures, and there is a need for improved cultural awareness and competence in the health care and mental health workforce.

Gender and Dependency on Others

Current research on mental health typically equates dependent behavior with negative health outcomes and thereby ignores how other people perceive dependency and mental illness in gendered ways. Using data from the Indianapolis Network Mental Health Study, Artis (1997) conducted a quantitative analysis of gender differences in the prevalence of network members' discussions of dependency, followed by a qualitative analysis of how network members describe dependency. The sex of the network member, together with the sex of the patient, significantly predicts discussions of dependency. Moreover, network members in same-sex dyads are more likely to discuss dependence than are their counterparts in opposite-sex dyads. The qualitative results provide a more contextualized understanding of the connections among gender, dependency, and mental
illness. Male network members' reports indicate strong censure of male patients for dependent behavior, while female network members' reports indicate that female patients see dependency in a more nuanced and complex way. In addition, network members in opposite-sex dyads are more accepting of dependent behavior than network members in same-sex dyads. These findings underscore the importance of examining how others perceive mental illness and how these perceptions may be gendered.

Rosenfield and Smith (2010) asked certain questions such as, are there differences between men and women in mental health and why? Evidence reveals that there are no differences in their overall rates of psychopathology, but men and women do differ in the type of psychopathology experienced. Women suffer from higher rates of depression and anxiety (referred to as internalizing disorders), and men have higher rates of substance abuse and antisocial disorders (referred to as externalizing disorders). They consider various explanations for these differences. They concentrate on dominant gender conceptions—those held by groups in positions of power, which in this society, are primarily White, middle-class conceptions. Divisions between men and women in power, responsibilities (i.e., different role positions), and personal characteristics are relevant for mental health. For example, women earn less money, have jobs with less power and autonomy, and experience an overload of job and family demands more often than men. They have closer social ties, which bring more support but also more negative interactions. Women have personal characteristics of low self-esteem and mastery compared to men, as well as high emotional reliance as opposed to men's greater independence. Finally, men and women differ in self-salience, which constitutes beliefs
about the importance of the self versus others in social relations: Women put others' interests first more often, which promotes internalizing problems, while men tend to privilege the self more strongly, facilitating externalizing problems. As African-Americans exemplify, the authors report that socializing practices encouraging high self-regard along with high regard for others benefit mental health.

Gender Issues in Mental Health

Women are more likely than men to experience internalizing disorders. Primary symptoms of internalizing disorders involve negative inner emotions as opposed to outward negative behavior. Depression (both mild and severe) and anxiety (generalized or "free-floating" anxiety, phobias, and panic attacks) are internalizing disorders common to women. Symptoms include sadness; a sense of loss, helplessness, or hopelessness; doubt about one's ability to handle problems; high levels of worry or nervousness; poor self-esteem; guilt, self-reproach, and self-blame; decreased energy, motivation, interest in life, or concentration; and problems with sleep or appetite (Friedrich, 2011).

Men are more likely than women to experience externalizing disorders. Externalizing disorders are characterized by symptoms involving negative outward behavior as opposed to internal negative emotions. Such externalizing disorders as substance abuse (both drugs and alcohol) and antisocial behavior (such as anger, hostility, aggression, violence, stealing, etc.) are common to men. Substance abuse results in such negative physical and social consequences as hallucinations, blackouts, physical dependency, job loss, divorce, arrests, organ and brain damage, and financial debt. Antisocial behavior impairs interpersonal relationships and can also result in negative
consequences in other areas of life, such as run-ins with the criminal justice system (Friedrich, 2011).

Men are not exempt from such internalizing disorders as anxiety and depression. In fact, one study found that high levels of masculinity appear to be related to depression in males. Some researchers feel that men's abuse of substances could be considered the male version of depression. Because male gender roles discourage admitting vulnerability, men may resort to substance abuse as a way of covering their feelings (Friedrich, 2011).

Men who adhere to rigid gender roles are also at a disadvantage in interpersonal relationships, especially intimate relationships. They may avoid emotional expressiveness, or may behave in domineering and hostile ways. These behaviors increase their risk of social isolation, disconnection from nurturance, and participation in unhealthy relationships (Friedrich, 2011).

Gender Significant in Relationship to African-Americans

Rosenfield, Phillips, and White (2006) conducted a study and found that strong and consistent gender differences exist in mental health problems and crime. Females suffer more from internalizing problems, including depression and anxiety, while males predominate in externalizing problems, which include delinquency, aggression, and substance abuse. These gender differences vary by race, however. Although gender differences in externalizing problems remain considerable across race, gender differences in internalizing problems are far greater for whites than African-Americans. In explaining these patterns, Rosenfield et al., (2006) perspective differs from prior theories in both
mental health and criminology by focusing on the intersection of gender and race in relation to both internalizing and externalizing problems. They propose that gender and race affect internalizing and externalizing problems through their impact on schemas about self-salience, which refer to beliefs about the importance of the self versus the collective in social relations. In testing this perspective, they examine a sample of white and African American males and females in adolescence, the point at which these patterns arise. They found that gender and race interact to shape schemas about self-salience. Furthermore, these differences in self-salience help to explain the disparities by gender and race in internalizing and externalizing problems.

Emotional Reliance

According to Turner and Turner (1999) past research has suggested the potential importance of considering emotional reliance, a dimension of interpersonal dependence, when addressing social and developmental risk factors for depression. Based on a probability sample of 1,393 adults aged 18-55 residing in Toronto, Canada, their study addresses gender differences in emotional reliance and the relevance of emotional reliance in explaining the gender-depression association. They also explore linkages between emotional reliance and status factors. Findings indicate that emotional reliance is significantly related to depression and that women report greater reliance than men, independent of social status factors like marital and parental status, education, income, and occupational prestige. Moreover, the positive association between emotional reliance and depression is greater for women. Several social status factors modify the relationship between gender and emotional reliance. Both education and occupational prestige reduce
reliance, and are particularly beneficial in this regard for women. Marriage, on the other hand, increases emotional reliance, especially for men.

Ryan, La Guardia, Solky-Butzel, Chirkov, and Kim (2005) did three studies to examine people's willingness to rely on others for emotional support. They propose that emotional reliance (ER) is typically beneficial to well-being. However, due to differing socialization and norms, ER is also expected to differ across gender and cultures. Further, following a self-determination theory perspective, they hypothesize that ER is facilitated by social partners who support one's psychological needs for autonomy, competence, and relatedness. Results from the studies supported the view that ER is generally associated with greater well-being and that it varies significantly across different relationships, cultural groups, and gender. Within-person variations in ER were systematically related to levels of need satisfaction within specific relationships, over and above between-person differences. The discussion focuses on the adaptive value and dynamics of ER.

Overholser (1990) looked at emotional reliance and social loss effects on depressive symptoms in a person. A reactive form of dependence has been proposed to occur when a person is undergoing a period of substantial stress and change. Overholser assessed 114 psychiatric inpatients categorized according to the presence or absence of social loss and their level of emotional reliance on others. Both emotional reliance and social loss were related to a variety of depressive symptoms. A significant interaction was observed between emotional reliance and social loss on depression severity as measured by the Beck Depression Inventory (BDI). In general, subjects high in emotional reliance but experiencing no social loss displayed higher levels of depression than emotionally
reliant subjects who had undergone a social loss. Patients reporting high emotional reliance on others, in the aftermath of a social loss, may be reacting to the loss and suffer from less-severe and less-chronic pathology. Subjects reporting excessive emotional reliance in the absence of any precipitating exit event may be displaying more of a trait-like pathology.

Assessing Self-Confidence

Having self-confidence does not mean that individuals will be able to do everything. Self-confident people may have expectations that are not realistic. However, even when some of their expectations are not met, they continue to be positive and to accept themselves. People who are not self-confident tend to depend excessively on the approval of others in order to feel good about themselves. As a result, they tend to avoid taking risks because they fear failure. They generally do not expect to be successful. They often put themselves down and tend to discount or ignore compliments paid to them. By contrast, self-confident people are willing to risk the disapproval of others because they generally trust their own abilities. They tend to accept themselves; they don't feel they have to conform in order to be accepted. Self-confidence is not necessarily a general characteristic which pervades all aspects of a person's life. Typically, individuals will have some areas of their lives where they feel quite confident, e.g., academics, athletics, while at the same time they do not feel at all confident in other areas, e.g., personal appearance, social relationships (Psychology Wiki, 2010).

Mitra, Nath, and Deb (2003) studied a comparison between the self-concept of depressive patients and normal population with respect to ideal-self, real-self and social-
self. A group of twenty-five depressive patients and twenty-five normal population aged between 25-55 years were selected purposively and they were matched in terms of age and gender. Depressive patients were selected from a Mental Health Centre in Kolkata following DSM-III criteria. For collection of data the Bengali version of The Miskimins Self Goal Inventory, 1972 (MSGI) was used. For statistical analysis of data 't-test' was applied. Findings revealed that depressive patients and the normal population differed significantly with respect to ideal-self, real-self and social-self i.e., these three components of self-concept were found to be stronger among the normal population than that of depressive patients. Although statistically there was no significant difference between real-self and ideal-self and real-self and social-self of depressive patients, idea-self was relatively better among them as compared to real-self and social-self. Qualitative analysis of data with regard to real-self of depressive patients indicates that they consider themselves to be less creative and unsuccessful in achieving goals in life. So far as social-self is concerned, depressive patients feel that they are incapable of solving problems encountered in daily life and unable to maintain cordial relationships with different social agents. They also lack self confidence.

Assertion of Autonomy

Gundy and Teresa (2001) drew from social psychological theories of stress and strain, to seek to understand gender differences in "internalizing" and "externalizing" manifestations of stress within a representative sample of 1,800 young adults in Miami-Dade County, Florida. Specifically, they examine mediating and moderating relationships between gender, stress, and three outcomes: depression, marijuana use, and criminal
behavior. They also assessed the extent to which gendered dimensions of interpersonal dependency emotional reliance and assertion of autonomy are psychologically beneficial or damaging when examining multiple stress outcomes between and within genders.

Findings corroborate previous research that suggests that women average higher depression, men average higher marijuana use and criminal behavior, and stress exposure increases risk for multiple stress outcomes. Additionally, results indicate that the positive influence of stress on marijuana use is more pronounced among young men than women. Moreover, interpersonal dependency dimensions are neither inherently harmful nor helpful when considering moderating effects of gender and stress exposure on multiple stress outcomes. The results speak to the limits of examining single stress outcomes and qualify conditions under which traditionally "feminine" and "masculine" interpersonal attributes may act as psychosocial resources or detriments in the stress process.

Afrocentric Perspective

According to Clark Atlanta University, Whitney M. Young, Jr., School of School Work classroom instruction (2010), the Afrocentric Perspective and Strength Based Practice Model are continually taught and are highly emphasized for current students to both understand and apply each into everyday practice among the diverse clients and communities with whom we will eventually serve. The Afrocentric Perspective embodies the ability and awareness for those that will be providing biopsychosocial human services with the knowledge to appreciate, respect, and come to understand the racial, ethnic, and cultural upbringings of others. By effectively applying the Afrocentric Perspective and
Strength Based Practice Model day to day will aid in addressing the various social problems of all diverse communities.

People living with a mental disorder are not specific to any one race or community. For those that are diagnosed with a mental disorder this is not just a medical issue but also a social problem which can have an impact on their day to day overall functioning in society. To help prepare future practitioners to serve the needs of mentally ill clients and their families, the Whitney M. Young, Jr., School of Social Work at Clark Atlanta University has set up within its curriculum to educate those in the undergraduate, graduate, as well the doctoral programs with courses that will teach the importance of utilizing the Afrocentric Perspective along with the Strength Based Practice Model in social work practice. The perspective and the model is heavily guided by humanistic values, and seeks to educate students to demonstrate a heightened sense of social consciousness to be creative, responsible social work professionals committed to the search for solutions to problems of poverty and varied forms of oppression in society while preserving the heritage of African-Americans as well as other races.

Also, the School supports and is committed to applying the core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence which are identified within the mission statement of the Code of Ethics set by the National Association of Social Workers (NASW). Each of these core values are in alignment with the Afrocentric Perspective to be responsible toward serving the oppressed; those that are at-risk members within society; and the application of professional values and ethics in practice (NASW, 2008).
Theoretical Framework: Attachment Theory

The current study addresses mentally ill clients and interpersonal dependency relationships from the Attachment Theoretical Perspective. John Bowlby and Mary Ainsworth founded modern attachment theory on studies of children and their caregivers. Children and caregivers remained the primary focus of attachment theory for many years. Then, in the late 1980s, Cindy Hazan and Phillip Shaver applied attachment theory to adult romantic relationships. Hazan and Shaver noticed that interactions between adult romantic partners shared similarities to interactions between children and caregivers. For example, romantic partners desire to be close to one another. Romantic partners feel comforted when their partners are present and anxious or lonely when their partners are absent. Romantic relationships serve as secure bases that help partners face the surprises, opportunities, and challenges life presents. Similarities such as these led Hazan and Shaver to extend attachment theory from children and caregivers to adult romantic relationships (Wikipedia, 2010).

Applying some of the core principles within the Attachment Theory’s approach to this study helps to identify the type of attachment relationship an adult with a mental illness may have toward others which is being measured through the participants’ emotional reliance on others, their level of self confidence and their ability to assert autonomy.

As Hazan and Shaver (1987) extended upon Bowlby and Ainsworth work, their focus looked at the attachment among adults as it deals in adult romantic relationships. This study is also focusing on attachment among adults but not the romantic or intimate
involvement of those with a significant other, but on how much those with a mental disorder may or may not depend on others to psychosocially function from day to day.

Hazan and Shaver (1987) identified four styles of attachment in adults: secure, anxious-preoccupied, dismissive-avoidant, and fearful-avoidant. Investigators have explored the organization and the stability of mental working models that underlie these attachment styles. They have also explored how attachment impacts relationship outcomes and how attachment functions in relationship dynamics.

Attachment Styles

Hazan and Shaver (1987) explained the four styles of attachment as follow. The secure attachment style in adults corresponds to the secure attachment style in children. The anxious-preoccupied attachment style in adults corresponds to the anxious/ambivalent attachment style in children. However, the dismissive avoidant attachment style and the fearful avoidant attachment style, which are distinct in adults, correspond to a single avoidant attachment style in children. The descriptions of adult attachment styles offered below are based on the relationship questionnaire devised by Bartholomew and Horowitz and on a review of studies by Pietromonaco and Barrett.

Secure Attachment

Securely attached people tend to agree with the following statements: "It is relatively easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don't worry about being alone or having others not accept me." This style of attachment usually results from a history of warm and responsive interactions with relationship partners. Securely attached people tend to
have positive views of themselves and their partners. They also tend to have positive views of their relationships. Often they report greater satisfaction and adjustment in their relationships than people with other attachment styles. Securely attached people feel comfortable both with intimacy and with independence. Many seek to balance intimacy and independence in their relationship (Hazan, 1987).

For this study having a secure attachment for those with a mental illness is likely to be identified by those participants who also may have a balanced and stable relationship with others but at the same time have a level of independence to do for self with the ability to assert autonomy.

Anxious-preoccupied Attachment

People who are anxious or preoccupied with attachment tend to agree with the following statements:

"I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them."

People with this style of attachment seek high levels of intimacy, approval, and responsiveness from their partners. They sometimes value intimacy to such an extent that they become overly dependent on their partners—a condition colloquially termed clinginess. Compared to securely attached people, people who are anxious or preoccupied with attachment tend to have less positive views about themselves. They often doubt their worth as a partner and blame themselves for their partners' lack of responsiveness. People
who are anxious or preoccupied with attachment may exhibit high levels of emotional expressiveness, worry, and impulsiveness in their relationships (Hazan, 1987).

For this study having an anxious or preoccupied attachment for those with a mental illness is likely to be identified by those participants who have a lack of self confidence about their capabilities to interact successfully around with others.

Dismissive-avoidant Attachment

People with a dismissive style of avoidant attachment tend to agree with these statements: "I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depended on me." People with this attachment style desire a high level of independence. The desire for independence often appears as an attempt to avoid attachment altogether. They view themselves as self-sufficient and invulnerable to feelings associated with being closely attached to others. They often deny needing close relationships. Some may even view close relationships as relatively unimportant. Not surprisingly, they seek less intimacy with relationship partners, whom they often view less positively than they view themselves. Investigators commonly note the defensive character of this attachment style. People with a dismissive-avoidant attachment tend to suppress and hide their feelings, and they tend to deal with rejection by distancing themselves from the sources of rejection (i.e., their relationship partners) (Hazan, 1987).

For this study having a dismissive-avoidant attachment for those with a mental illness is likely to be identified by those participants who are also self sufficient and have a level of independence to do for themselves without the need to depend on others as they
are able to assert autonomy. These participants are likely to respond heavily in favor of independent living and less emotional reliant to depend on others by avoiding attachment altogether.

**Fearful-avoidant Attachment**

People with a fearful style of avoidant attachment tend to agree with the following statements: "I am somewhat uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I sometimes worry that I will be hurt if I allow myself to become too close to others."

People with this attachment style have mixed feelings about close relationships. On the one hand, they desire to have emotionally close relationships. On the other hand, they tend to feel uncomfortable with emotional closeness. These mixed feelings are combined with negative views about themselves and their partners. They commonly view themselves as unworthy of responsiveness from their partners, and they don't trust the intentions of their partners. Similarly to the dismissive-avoidant attachment style, people with a fearful-avoidant attachment style seek less intimacy from partners and frequently suppress and hide their feelings (Hazan, 1987).

For this study having a fearful-avoidant attachment for those with a mental illness is likely to be identified by those participants who would want to be close with others but manifest a lack of self confidence through fear of being hurt which impacts their ability to freely or willingly interact with others. This may prevent them from developing an emotional reliance to depend on others and force them to live more independently.
CHAPTER III

METHODOLOGY

Chapter III delineates the methodology procedures that were utilized in producing the final assessment of the study. The following are discussed in this chapter: research design, description of the site, sample and population, instrumentation, treatment of data, and limitations of the study.

Research Design

The task of this study is to assess interpersonal dependency relationships among African-American men and women that they may require from others. In addition, the study wants to further assess what particular mental disorders the participants are diagnosed with that leads to the greatest dependency on others. To determine if there is a relationship amongst these factors, participants were asked to answer a questionnaire.

The questionnaire was revised from a similar study conducted by Hirschfeld, Klerman, Gough, Barrett, Korchin, and Chodoff (1977) using their version of an Interpersonal Dependency Inventory scale (IDI) to measure interpersonal dependency. The IDI scale theoretical framework included a blend of psychoanalytic, social learning, and attachment theories which emphasized the importance of excess dependency to a range of emotional and behavioral disorders.

The IDI questionnaire included forty-eight items using a 4-point Likert scale which measured the variables emotional reliance on others, lack of self-confidence, and
assertion of autonomy. For this particular study, nine of the 48 items were taken from the IDI questionnaire. Of the nine items chosen, three a piece were used to measure the variables emotional reliance, self-confidence, and autonomy.

The IDI scale’s reliability had good internal consistency and validity was fairly good. The test correlates with social desirability of Minnesota Multiphasic Personality Inventory (MMPI). The MMPI is one of the most frequently used personality tests in mental health. The test is used by trained professionals to assist in identifying personality structure and psychopathology (Wikipedia, 2010).

The IDI scale of measurement was found in Tzeng’s (1993) book that included many varieties of scales and strategies for the measurement of love and intimate relations with the intent to serve both research and clinical needs for further study of love development, maintenance, and dissolution. The book is titled: Measurement of love and intimate relations: theories, scales, and applications for love development, maintenance, and dissolution.

A descriptive design will be implemented in the study to compare among the adult men and women participants with a confirmed diagnosed mental disorder/s and then determine if there is an interpersonal dependency relationship they have on others as a part of their functioning from day to day.

Description of the Site

The participants were anonymously recruited from the West Fulton Mental Health Center located in Atlanta, Georgia. The agency’s main purpose and mission is to provide high quality and culturally competent behavioral health care outpatient services to the
most-in-need citizens of Fulton County. They offer a variety of treatment and rehabilitation services in a behavioral health care model that is designed to help clients achieve and maintain a level of independence and stability so they can live a productive lifestyle within their families and their community.

All of the participants have a documented mental disorder from a trained and licensed physician. Also, it is documented in each participant’s medical chart that they are currently prescribed mental health medications as part of their treatment plan.

Sample and Population

The target population for this study consisted of only African-American men (N=25) and women (N=25) with a physician diagnosed mental disorder. Their ages ranged from 18 and 65. The Institutional Review Board (IRB) at Clark Atlanta University approved the collection of the data from the West Mental Health Center. All fifty participants were anonymously recruited. There were no monetary incentives offered or given to the participants for participating.

Instrumentation and Measures

A questionnaire was utilized as the assessment tool for the measurement of this study. The title of the questionnaire was “A Study Comparing African-American Men and Women with a Mental Health Disorder and Their Dependency on Others.” The questionnaire was divided into two sections. The first section requested demographic information from the participants which was titled “Section I.” The first section contained seven questions. The next section was entitled, “Section II: How much do you agree with the following statements?” Section II was divided into three different sections which
contained a total of nine questions; there were three questions in each section. The questionnaire measured the participants’ agreeability. A Likert Scale (4=I totally agree, 3=I agree, 2=I disagree, 1=I totally disagree) was used to analyze each participant’s perception of emotional reliance, lack of self confidence, and assertion of autonomy as it related to their level of dependency on others.

The first section of Section II was entitled: “Emotional reliance on others.” Questions eight through ten: I do my best work when I know it will be appreciated (ERBEST); I believe people could do a lot more for me if they wanted to (ERPEOPL); and I would be completely lost if I didn’t have someone special (ERLOST). The three questions ([ERBEST + ERPEOPL + ERLOST]/3) structure the computed variable (EMOTION) that is used in measuring the perception about emotional reliance on others thus examining the relationship with a mental health disorder by gender.

The second section of Section II was entitled: “Lack of self-confidence.” Questions eleven through thirteen: I would rather be a follower than a leader (LCWOULD); it is hard for me to ask someone for a favor (LCHARD); and in an argument, I give in easily (LCGIVE). The three questions ([LCWOULD + LCHARD + LCGIVE]/3) structure the computed variable (CONFIDE) that is used in measuring the perception about lack of self confidence thus examining the relationship with a mental health disorder by gender.

The third section of Section II was entitled: “Assertion of autonomy.” Questions fourteen through sixteen: I prefer to be by myself (AAPREF); I don’t need other people to make me feel good (AADONT); and when I am sick, I prefer my friends to leave me
alone (AASICK). The three questions ([AAPREF + AADONT + AASICK]/3) structure the computed variable (AUTONMY) that is used in measuring the perception about assertion of autonomy thus examining the relationship with a mental health disorder by gender.

The participant’s perception about emotional reliance (EMOTION), lack of self-confidence (CONFIDE), and assertion of autonomy (AUTONMY) will define their dependency on others. Dependency on others will be determined by using the formula: DEPEND = EMOTION + CONFIDE – AUTONMY. The higher the score the more likely the respondent will have a greater dependency on others.

Treatment of Data

The Statistical Package for Social Sciences (SPSS) was used to analyze the data presented by the participants. The evaluation employed the descriptive statistics, which incorporated frequency distribution and cross-tabulation which then compared the relationships.

The demographic profile included questions that identified the participant’s gender, age group, relationship status, employment, confirming to have a mental disorder, what specific mental disorder/s, and how long they had been diagnosed with a mental disorder. A frequency distribution analyzed the data and a cross-tabulation was utilized in comparing gender with a mental disorder to examine the relationship with the three variables of the study.
A frequency distribution of the demographic information was utilized to obtain acuity about the participants in the study. Frequency distributions were also used to examine and shorten the variables in the study.

Cross-tabulations were used to reveal the statistical relationship between the variables of the study. Cross-tabulations were computed between the variables, perception about their emotional reliance (EMOTION), perception about their confidence (CONFIDE), and perception about their autonomy (AUTONMY). The formula: \[ \text{DEPEND} = \text{EMOTION} + \text{CONFIDE} - \text{AUTONMY} \] was used and the higher the score from the formula meant the more likely the respondent will have a greater dependency on others.

Limitations of the Study

There were several limitations in this study that must be noted. The first limitation of the study was the number of participants (N=50). Gathering twenty-five questionnaires from each gender is not a significant amount to adequately represent the population at large. The second limitation was the number of participants with a particular disorder was also not a significant amount to adequately represent the population at large. The third limitation was, some participants have more than one mental disorder; therefore, it cannot be determined definitively which particular disorder or is there a combination of each disorder contributing to their dependency on others. The final limitation, according to the participants’ medical chart they were all prescribed mental health medications. It was not for certain that the participants have actual been
taking their medications on a consistent basis which could factor in how they responded on the questionnaire because of their current emotional and mental state at that time.
CHAPTER IV
Presentation of Findings

The intention of this chapter is to present the findings of the final evaluation of the study. The questionnaires were administered to African American men and women. These persons were participants of a community mental health center for adults located in Atlanta, Georgia. The purpose of this study was to compare men and women with a mental disorder to find out if either had a dependency on others for social functioning. Also, to compare among several specific mental health disorders to find out which depended on others for social functioning. The results of the study are computed into two sections: demographic data and research question and hypothesis.

Demographic Data

The demographic profile consisted of the following: gender, age group, relationship status, employment status, if diagnosed with a mental disorder, what specific mental disorder, and how long diagnosed with the disorder. The study population was composed of 50 questionnaires which were given to 25 African American men and 25 African American women with all having a diagnosed mental health disorder. The participant’s age groups are the following: 20-29 (N=3), 30-39 (N=14), 40-49 (N=16), 50-59 (N=13), and 60-older (N=4). Thirty of the participants had never married, two were engaged, four married, one separated, six divorced, three co-habited together, and four were widowed. Forty-one were unemployed. Seven were diagnosed with Anxiety,
nine Bipolar, fifteen had Depression, fifteen Schizophrenia, and four were Others. Forty-three indicated being diagnosed for a year or more, six had been diagnosed for six-months up to a year, and only one was recently diagnosed.

Table 1

Demographic profile for participants (N=50)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Gender</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Age Range</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 and under</td>
<td>00</td>
<td>00</td>
</tr>
<tr>
<td>20-29</td>
<td>02</td>
<td>01</td>
</tr>
<tr>
<td>30-39</td>
<td>09</td>
<td>05</td>
</tr>
<tr>
<td>40-49</td>
<td>04</td>
<td>12</td>
</tr>
<tr>
<td>50-59</td>
<td>09</td>
<td>04</td>
</tr>
<tr>
<td>60 and older</td>
<td>01</td>
<td>03</td>
</tr>
<tr>
<td>Relationship Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Married</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>Engaged</td>
<td>00</td>
<td>02</td>
</tr>
<tr>
<td>Married</td>
<td>03</td>
<td>01</td>
</tr>
<tr>
<td>Separated</td>
<td>00</td>
<td>01</td>
</tr>
<tr>
<td>Divorced</td>
<td>01</td>
<td>05</td>
</tr>
<tr>
<td>Co-habiting</td>
<td>01</td>
<td>02</td>
</tr>
<tr>
<td>Widowed</td>
<td>01</td>
<td>03</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>05</td>
<td>04</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Diagnosed with Mental Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>No</td>
<td>00</td>
<td>00</td>
</tr>
</tbody>
</table>
Table 1 (continued)

| Variable                | Frequency | Percent | | | |
|-------------------------|-----------|---------| | | |
| **Mental Disorders**    |           |         | | | |
| Anxiety                 | 01        | 06      | 04.0          | 24.0          |
| Bipolar                 | 04        | 05      | 16.0          | 20.0          |
| Depression              | 05        | 10      | 20.0          | 40.0          |
| Schizophrenia           | 12        | 03      | 48.0          | 12.0          |
| Other                   | 03        | 01      | 12.0          | 04.0          |
| **How long been diagnosed** |           |         | | | |
| Recently                 | 01        | 00      | 04.0          | 00.0          |
| About 6 months to a year| 00        | 06      | 00.0          | 24.0          |
| A year or more          | 24        | 19      | 96.0          | 76.0          |

Table 1 is a profile of the study participants. The table portrays the frequency distribution of the participants’ demographic variables utilized in the study.

As depicted in Table 1, the typical respondent of African American men were between the ages of 30 and 39 along with those who were 50 and 59, that never married, that were unemployed, with a Schizophrenia mental health disorder and have been living with their disorder for a year or more. The typical respondent of African American women were between the ages of 40 and 49, that never married, that were unemployed, with a Depression mental health disorder and have been living with their disorder for a year or more.
### Table 2

*I do my best work when I know it will be appreciated (N=50)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>I agree</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>I disagree</td>
<td>03</td>
<td>05</td>
</tr>
</tbody>
</table>

Total: 25 25 100% 100%

Table 2 is a frequency distribution of 50 participants that responded to doing their best work is when they know it will be appreciated. Of the 50 participants, the typical respondents were 88% men who agreed and 80% of the women also agreed. Overall, both men and women agreed that they will do their best work when they know it will be appreciated.

### Table 3

*I believe people could do a lot more for me if they wanted to (N=50)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>I agree</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>I disagree</td>
<td>08</td>
<td>08</td>
</tr>
</tbody>
</table>

Total: 25 25 100% 100%
Table 3 is a frequency distribution of 50 participants that responded to their beliefs that people could do a lot more for them if they wanted to. Of the 50 participants, the typical respondents were 68% men who agreed and likewise 68% of the women also agreed. Overall, both men and women equally agreed that people could do a lot more for them if they wanted to.

Table 4

*I would be completely lost if I didn’t have someone special (N=50)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>I agree</td>
<td>17</td>
<td>07</td>
</tr>
<tr>
<td>I disagree</td>
<td>08</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

Table 4 is a frequency distribution of 50 participants that responded to being completely lost if they did not have someone special in their lives. Of the 50 participants, the typical respondents were 68% men who agreed whereas 72% of the women disagreed. Overall, men agreed to be completely lost if they did not have someone special in their lives; however, women do not.
Table 5

*I would rather be a follower than a leader* (N=50)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>I agree</td>
<td>06</td>
<td>09</td>
</tr>
<tr>
<td>I disagree</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

Table 5 is a frequency distribution of 50 participants that responded to they would rather be a follower than a leader. Of the 50 participants, the typical respondents were 76% men who disagreed whereas 64% of the women also disagreed. Overall, both men and women disagreed that they would rather be a follower than a leader.

Table 6

*It is hard for me to ask someone for a favor* (N=50)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>I agree</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>I disagree</td>
<td>13</td>
<td>07</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>
Table 6 is a frequency distribution of 50 participants that responded to it is hard for them to ask someone for a favor. Of the 50 participants, the typical respondents were 52% men who disagreed whereas 72% of the women agreed. Overall, women agreed it is hard for them to ask someone for a favor; however, a little more than half of the men do not.

Table 7

*In an argument, I give in easily (N=50)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>I agree</td>
<td>14</td>
<td>09</td>
</tr>
<tr>
<td>I disagree</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

Table 7 is a frequency distribution of 50 participants that responded to in an argument they give in easily. Of the 50 participants, the typical respondents were 56% men who agreed whereas 64% of the women disagreed. Overall, men agreed that in an argument they would give in easily; however, women do not.
Table 8

*I prefer to be by myself (N=50)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>I agree</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>I disagree</td>
<td>12</td>
<td>09</td>
</tr>
</tbody>
</table>

| Total        | 25        | 25      | 100%  | 100%   |

Table 8 is a frequency distribution of 50 participants that responded to whether they prefer to be by themselves. Of the 50 participants, the typical respondents were 52% men who agreed and likewise 64% of the women also agreed. Overall, both men and women agreed that they prefer to be by themselves.

Table 9

*I don’t need other people to make me feel good (N=50)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>I agree</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>I disagree</td>
<td>09</td>
<td>09</td>
</tr>
</tbody>
</table>

| Total        | 25        | 25      | 100%  | 100%   |
Table 9 is a frequency distribution of 50 participants that responded to whether or not if they needed other people to make them feel good. Of the 50 participants, the typical respondents were 64% men who agreed and likewise 64% of the women also agreed. Overall, both men and women equally agreed that they don’t need other people to make them feel good.

Table 10

*When I am sick, I prefer my friends to leave me alone (N=50)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>agree</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>disagree</td>
<td>14</td>
<td>09</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

Table 10 is a frequency distribution of 50 participants that responded to when they are sick they prefer their friends to leave them alone. Of the 50 participants, the typical respondents were 56% men who disagreed whereas 64% of the women agreed. Overall, women preferred their friends to leave them alone when they are sick; however, a little more than half of the men do not.
Table 11

*Cross-tabulation of the computed variable (EMOTION) participant’s perception about emotional reliance on others by demographic variable (GENDER). (N=50)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td><strong>EMOTIONAL RELIANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I agree</td>
<td>15</td>
<td>09</td>
</tr>
<tr>
<td>I disagree</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

df = 1  p = .089

Table 11 is a frequency distribution for the computed variable of perception about emotional reliance on others by the variable gender. Three questions from the assessment tool were used to form the computed variable reliance toward their perception about emotional reliance on others (EMOTION): I do my best work when I know it will be appreciated (ERBEST); I believe people could do a lot more for me if they wanted to (ERPEOPL); and I would be completely lost if I didn’t have someone special (ERLOST). The three questions ([ERBEST + ERPEOPL + ERLOST]/3) structure the computed variable (EMOTION) that is used in measuring the perception about emotional reliance on others by the variable (GENDER).

Table 11, depicted that more men agreed to have an emotional reliance on others than women. Of the 50 participants, the computed variable (EMOTION) revealed 60%
of men agreed to have an emotional reliance on others; however, the computed variable (EMOTION) revealed 64% of the women did not.

As shown in Table 11, when the chi-square statistical test for significance was applied, the null hypothesis was not rejected ($p = .089$) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

Table 12

*Cross-tabulation of the computed variable (CONFIDE) participant's perception about lack of self confidence by demographic variable (GENDER). (N=50)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>LACK OF SELF CONFIDENCE</td>
<td>I agree</td>
<td>06</td>
<td>07</td>
<td>24.0</td>
</tr>
<tr>
<td></td>
<td>I disagree</td>
<td>19</td>
<td>18</td>
<td>76.0</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>25</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

$df = 1$  

$p = .747$

Table 12 is a frequency distribution for the computed variable of perception about lack of self confidence by the variable gender. Three questions from the assessment tool were used to form the computed variable confide toward their perception about lack of self confidence (CONFIDE): I would rather be a follower than a leader (LCWOULD); it is hard for me to ask someone for a favor (LCHARD); and in an argument, I give in
easily (LCGIVE). The three questions ([LCWOULD + LCHARD + LCGIVE]/3) structure the computed variable (CONFIDE) that is used in measuring the perception about lack of self confidence by the variable (GENDER).

Table 12, depicted that both men and women disagreed to having a lack of self confidence. Of the 50 participants, the computed variable (CONFIDE) revealed 76% of men disagreed to having a lack of self confidence and likewise the computed variable (CONFIDE) revealed 72% of the women also disagreed.

As shown in Table 12, when the chi-square statistical test for significance was applied, the null hypothesis was not rejected ($p = .747$) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

Table 13

*Cross-tabulation of the computed variable (AUTONMY) participant’s perception about lack of self confidence by demographic variable (GENDER). (N=50)*

<table>
<thead>
<tr>
<th>GENDER Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>ASSERTION OF AUTONOMY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I agree</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>I disagree</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

$df = 1$, $p = .157$
Table 13 is a frequency distribution for the computed variable of perception about assertion of autonomy by the variable gender. Three questions from the assessment tool were used to form the computed variable autonomy toward their perception about assertion of autonomy (AUTONMY): I prefer to be by myself (AAPREF); I don’t need other people to make me feel good (AADONT); and when I am sick, I prefer my friends to leave me alone (AASICK). The three questions ([AAPREF + AADONT + AASICK]/3) structure the computed variable (AUTONMY) that is used in measuring the perception about assertion of autonomy by the variable (GENDER).

Table 13, depicted that more women agreed to the assertion of autonomy than men. Of the 50 participants, the computed variable (AUTONMY) revealed 60% of women agreed to the assertion of autonomy; however, the computed variable (AUTONMY) revealed 60% of the men disagreed.

As shown in Table 13, when the chi-square statistical test for significance was applied, the null hypothesis was not rejected ($p = .157$) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.
Table 14

Cross-tabulation comparison of the computed variable (EMOTION) for the participants' perception about their dependency on others by the demographics variable (DISORDE). (N=50)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
<td>Disagree</td>
</tr>
<tr>
<td><strong>MENTAL DISORDER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Count</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>%of Total</td>
<td>2%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>Count</td>
<td>06</td>
</tr>
<tr>
<td></td>
<td>%of Total</td>
<td>12%</td>
</tr>
<tr>
<td>Depression</td>
<td>Count</td>
<td>04</td>
</tr>
<tr>
<td></td>
<td>%of Total</td>
<td>8%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Count</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>%of Total</td>
<td>22%</td>
</tr>
<tr>
<td>Other</td>
<td>Count</td>
<td>02</td>
</tr>
<tr>
<td></td>
<td>%of Total</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Count</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>%of Total</td>
<td>48%</td>
</tr>
</tbody>
</table>

\[ df = 4 \quad p = .026 \]
Table 14 is a frequency distribution for the computed variable of perception about emotional reliance on others by the variable emotion. Three questions from the assessment tool were used to form the computed variable reliance toward their perception about emotional reliance on others (EMOTION): I do my best work when I know it will be appreciated (ERBEST); I believe people could do a lot more for me if they wanted to (ERPEOPL); and I would be completely lost if I didn’t have someone special (ERLOST). The three questions ([ERBEST + ERPEOPL + ERLOST]/3) structure the computed variable (EMOTION) that is used in measuring the perception about emotional reliance on others by the variable (DISORDE).

Table 14, depicted that those diagnosed with Schizophrenia agreed the most to having an emotional reliance in comparison to those with Anxiety, Bipolar, Depression, and Others. Also, those diagnosed with Depression disagreed more to having an emotional reliance in comparison to those with Anxiety, Bipolar, Schizophrenia, and Others. Of the 50 participants, the computed variable (EMOTION) revealed 22% of those diagnosed with Schizophrenia agreed the most to having an emotional reliance; whereas, the computed variable (EMOTION) revealed 22% of those diagnosed with Depression disagreed to having an emotional reliance. Of significance, 52% of those with a mental health disorder combined disagreed to having an emotional reliance.

As shown in Table 14, when the chi-square statistical test for significance was applied, the null hypothesis was not rejected (p = .026) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.
Table 15

Cross-tabulation comparison of the computed variable (CONFIDE) for the participants' perception about their dependency on others by the demographics variable (DISORDE). (N=50)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
<td>Disagree</td>
</tr>
<tr>
<td><strong>MENTAL DISORDER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Count</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>%of Total</td>
<td>2%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>Count</td>
<td>04</td>
</tr>
<tr>
<td></td>
<td>%of Total</td>
<td>8%</td>
</tr>
<tr>
<td>Depression</td>
<td>Count</td>
<td>04</td>
</tr>
<tr>
<td></td>
<td>%of Total</td>
<td>8%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Count</td>
<td>03</td>
</tr>
<tr>
<td></td>
<td>%of Total</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>Count</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>%of Total</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Count</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>%of Total</td>
<td>26%</td>
</tr>
</tbody>
</table>

\[ df = 4 \quad p = .667 \]
Table 15 is a frequency distribution for the computed variable of perception about emotional reliance on others by the variable confide. Three questions from the assessment tool were used to form the computed variable confide toward their perception about lack of self confidence (CONFIDE): I would rather be a follower than a leader (LCWOULD); it is hard for me to ask someone for a favor (LCHARD); and in an argument, I give in easily (LCGIVE). The three questions ([LCWOULD + LCHARD + LCGIVE]/3) structure the computed variable (CONFIDE) that is used in measuring the perception about lack of self confidence by the variable (DISORDE).

Table 15, depicted that those diagnosed with both Depression and Bipolar agreed the most to having a lack of self confidence in comparison to those with Anxiety, Schizophrenia, and Others. Also, those diagnosed with Schizophrenia disagreed more to having a lack of self confidence in comparison to those with Anxiety, Bipolar, Depression, and Others. Of the 50 participants, the computed variable (CONFIDE) revealed 8% of those diagnosed with both Depression and Bipolar agreed the most to having a lack of self confidence; whereas, the computed variable (CONFIDE) revealed 22% of those diagnosed with Depression disagreed the most. Of significance, 74% of those with a mental health disorder combined disagreed to having a lack of self confidence.

As shown in Table 15, when the chi-square statistical test for significance was applied, the null hypothesis was not rejected (p = .667) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.
Table 16

Cross-tabulation comparison of the computed variable (AUTONMY) for the participants' perception about their dependency on others by the demographics variable (DISORDE). (N=50)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENTAL DISORDER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Count</td>
<td>04</td>
</tr>
<tr>
<td>Bipolar</td>
<td>Count</td>
<td>06</td>
</tr>
<tr>
<td>Depression</td>
<td>Count</td>
<td>07</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Count</td>
<td>05</td>
</tr>
<tr>
<td>Other</td>
<td>Count</td>
<td>03</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>25</td>
</tr>
</tbody>
</table>

**Assertion of Autonomy**

$$\text{df} = 4 \quad p = .667$$
Table 16 is a frequency distribution for the computed variable of perception about assertion of autonomy by the variable autonomy. Three questions from the assessment tool were used to form the computed variable autonomy toward their perception about assertion of autonomy (AUTONMY): I prefer to be by myself (AAPREF); I don’t need other people to make me feel good (AADONT); and when I am sick, I prefer my friends to leave me alone (AASICK). The three questions ([AAPREF + AADONT + AASICK]/3) structure the computed variable (AUTONMY) that is used in measuring the perception about assertion of autonomy by the variable (DISORDE).

Table 16, depicted that those diagnosed with Depression agreed the most to assertion of autonomy in comparison to those with Anxiety, Bipolar, Schizophrenia, and Others. Also, those diagnosed with Schizophrenia disagreed more to assertion of autonomy in comparison to those with Anxiety, Bipolar, Depression, and Others. Of the 50 participants, the computed variable (AUTONMY) revealed 14% of those diagnosed with Depression agreed the most to assertion of autonomy; whereas, the computed variable (AUTONMY) revealed 20% of those diagnosed with Schizophrenia disagreed the most. Of significance, half of those with a mental health disorder agreed to the assertion of autonomy.

As shown in Table 16, when the chi-square statistical test for significance was applied, the null hypothesis was not rejected ($p = .423$) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.
Table 17

Cross-tabulation comparison of the computed variable (DEPEND) for the participants' perception about their dependency on others by the demographics variable (GENDER). (N=50)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>DEPENDENCY ON OTHERS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I agree</td>
<td>13</td>
<td>04</td>
</tr>
<tr>
<td>I disagree</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

df = 1  \( p = .007 \)

Table 17 is a frequency distribution for the computed variable of dependency on others by the variable gender. The computed variable depend (DEPEND) was developed using the formula: DEPEND = EMOTION + CONFIDE – AUTONMY.

Table 17, depicted that more women disagreed to being dependent on others than men did. Of the 50 participants, the computed variable (DEPEND) revealed 84% of women disagreed to having a dependency on others; whereas, the computed variable (DEPEND) revealed 52% of the men agreed they did.

As shown in Table 17, when the chi-square statistical test for significance was applied, the null hypothesis was not rejected \( (p = .007) \) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.
Table 18

Cross-tabulation comparison of the computed variable (DEPEND) for the participants’ perception about their dependency on others by the demographics variable (DISORDE). (N=50)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
<td>Disagree</td>
</tr>
<tr>
<td>MENTAL DISORDER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>01</td>
<td>06</td>
</tr>
<tr>
<td>%of Total</td>
<td>2%</td>
<td>12%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>02</td>
<td>07</td>
</tr>
<tr>
<td>%of Total</td>
<td>4%</td>
<td>14%</td>
</tr>
<tr>
<td>Depression</td>
<td>04</td>
<td>11</td>
</tr>
<tr>
<td>%of Total</td>
<td>8%</td>
<td>22%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>08</td>
<td>07</td>
</tr>
<tr>
<td>%of Total</td>
<td>16%</td>
<td>14%</td>
</tr>
<tr>
<td>Other</td>
<td>02</td>
<td>02</td>
</tr>
<tr>
<td>%of Total</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>33</td>
</tr>
<tr>
<td>%of Total</td>
<td>34%</td>
<td>66%</td>
</tr>
</tbody>
</table>

df = 4            

p = .279
Table 18 is a frequency distribution for the computed variable of dependency on others by the variable disorde. The computed variable depend (DEPEND) was developed using the formula: DEPEND = EMOTION + CONFIDE – AUTONMY.

Table 15, depicted that those diagnosed with Schizophrenia agreed the most to having a dependency on others in comparison to those with Anxiety, Bipolar, Depression, and Others. Also, those diagnosed with Depression disagreed more to having a dependency on others in comparison to those with Anxiety, Bipolar, Schizophrenia, and Others. Of the 50 participants, the computed variable (DEPEND) revealed 16% of those diagnosed with Schizophrenia agreed the most to having a dependency on others; whereas, the computed variable (DEPEND) revealed 22% of those diagnosed with Depression disagreed the most. Of significance, from all of the mental disorders being studied those with Schizophrenia are more dependent on others.

As shown in Table 18, when the chi-square statistical test for significance was applied, the null hypothesis was not rejected ($p = .279$) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.
Research Question and Hypothesis

Research Question: Do males diagnosed with a mental health disorder depend more on others than females with a mental health disorder?

Null hypothesis: There is no difference between males with a mental health disorder being dependent on others than females with a mental health disorder.

Alternative hypothesis: There is a difference between males with a mental health disorder being dependent on others than females with a mental health disorder.
CHAPTER V
DISCUSSION OF FINDINGS

This study compared African American men and women with a diagnosed mental illness to identify by gender who depended more on others for some form of support or assistant for social functioning. Also, the study compared dependency on others among several mental health disorders; specifically the Axis I disorders within the DSM-IV. The intention of this research was to recognize, define, and address this biopsychosocial issue.

Summary of the Study

Research Question: Do males diagnosed with a mental health disorder depend more on others than females with a mental health disorder?

A cross-tabulation was completed to determine if there was a significant relationship between those with a mental health disorder and dependency on others. Also, a cross-tabulation was completed to determine if there was a significant relationship among specific mental disorders and dependency on others.

The first cross-tabulation consisted of the participants by gender and their perception of being dependent on others using the computed formula: \( \text{DEPEND} = \text{EMOTION} + \text{CONFIDE} - \text{AUTONMY} \). The computed variable (DEPEND) was cross-tabulated with the demographic variable (GENDER). The results of this comparative
study indicated that more women disagreed to being dependent on others than the men did. Of the 50 participants, the computed variable (DEPEND) revealed 84% of women disagreed to having a dependency on others; whereas, the computed variable (DEPEND) revealed 52% of the men agreed they did.

When the chi-square statistical test for significance was applied, the null hypothesis was not rejected ($p = .007$) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

The findings suggest that African American women with a mental illness do not depend on others for social functioning and they are likely to be independent enough to do for themselves. However, a little over 50% of African American men with a mental illness did report dependency on others for social functioning.

Another cross-tabulation consisted of the participants with specific mental health disorders and their perception of being dependent on others using the same computed formula: $\text{DEPEND} = \text{EMOTION} + \text{CONFIDE} - \text{AUTONMY}$. The computed variable (DEPEND) was cross-tabulated with the demographic variable (DISORDE).

The results of this comparative study indicated that those diagnosed with Schizophrenia agreed the most to having a dependency on others in comparison to those with Anxiety, Bipolar, Depression, and Others. Also, those diagnosed with Depression disagreed more to having a dependency on others in comparison to those with Anxiety, Bipolar, Schizophrenia, and Others. Of the 50 participants, the computed variable (DEPEND) revealed 16% of those diagnosed with Schizophrenia agreed the most to
having a dependency on others; whereas, the computed variable (DEPEND) revealed
22% of those diagnosed with Depression disagreed the most.

When the chi-square statistical test for significance was applied, the null
hypothesis was not rejected ($p = .279$) indicating that there was a statistically significant
relationship between the two variables at the .05 level of probability.

The findings suggest that those participants with Schizophrenia depend more on
others for social functioning than those with Anxiety, Bipolar, Depression, and other or
multiple mental disorders. However, those participants with Depression depend more on
others for social functioning than those with Anxiety, Bipolar, Schizophrenia, and other
or multiple mental disorders.

Implications for Social Work

It is my recommendation that each of the four mental disorders (Anxiety, Bipolar,
Depression, and Schizophrenia) be further investigated to include a larger sample
population of African American men and women diagnosed with each mental disorder.
Additional research can be studied using participants with multiple mental disorders to
determine if dependency on others is a result of a particular disorder or from a
combination of having several disorders. Also, research can be conducted to include
participants with co-occurring conditions of having a mental disorder along with a
substance usage disorder to assess their level of dependency on others. Finally, modify
this current study or formulate a new study to investigate participants with a mental
disorder who are actually taking their prescribed medications on a consistent basis with
those who are not taking them to determine if dependency on others will be a result.
As reported by NIMH (2000), African Americans and other diverse communities are underserved by the nation's mental health system; therefore it will be very important for those that are in the social work profession to play vital roles in their practice on behalf of these clients, to ensure that their health and mental health needs do not go unmet.

It may prove to be a challenge to expect all clients living with a severe mental disorder such as those under Axis I of the DSM-IV to live self-sufficient and function from day-to-day independently. As practitioners we must first address their basic daily survival needs in the areas of food, clothing, shelter, along with their overall health including their mental illness.

As we start to address housing, food, clothing, and the medical necessities for our clients we need to have ready and available an array of services and resources to link them to, while at the same time assuring the services and resources are easily accessible, affordable, and reliable with the goal in mind of effectively reducing additional stressors for them to be concerned with. If there are any social benefits that our clients are eligible for and would most likely qualify to receive such as food stamps, Social Security Income, Section 8 housing, Medicaid or Medicare, then we should assist them in obtaining them.

For most clients with a severe mental illness, obtaining and maintaining gainful employment might be difficult on their behalf but for those who have the desire and are able to work we should refer them to employment agencies that cater specifically to the mentally ill which may consist of some form of Vocational Rehabilitation training or getting enrolled into school. Once employed, our clients can receive steady income to pay
bills and use toward other expenses. Again, getting a job or even going to school may prove to be a challenge for some; therefore, we as practitioners should encourage our clients to do some volunteer work in their community which will promote social activity and productivity.

As practitioners we should assess our clients' hobbies and interests and then seek to motivate them to be proactive in engaging in them. This could include exercising, traveling, going to church, etc. with the goal of enhancing their overall health and well-being.

The importance of family involvement can also enhance the overall day-to-day functioning of our clients as a support mechanism at social gatherings, for transportation, and, if able, for the basic needs of food, clothes, and shelter. Some family members find it very difficult to deal with a member with a severe mental disorder and prefer not to be bothered. As practitioners we can educate family members more about mental illness, medications, and community resources that are available for their loved ones.

As part of our clients' mental health well being, getting them and interested family members into effective group therapeutic sessions which can range from family therapy group, a task group, a sensitivity group, an educational group, or a self-help group will also benefit their overall biopsychosocial functioning. As the finding of this study revealed that men with mental disorders were more dependent on others than women, it might be beneficial to find gender specific resources and services tailored to men that will help enhance them to become more independent.
Finally, we must always remain at the forefront in the role as an advocate for our clients to fight to eliminate social injustices or negative stigmas. We as social workers should intervene on behalf of our clients before community leaders, politicians, the legal system and any agency or organization that has a major influence on what can or should be done to help or could hinder our clients from obtaining any communal resources, services, benefits and/or entitlements.
APPENDICES
APPENDIX A

SURVEY QUESTIONNAIRE
A STUDY COMPARING AFRICAN-AMERICAN MEN AND WOMEN WITH A MENTAL
HEALTH DISORDER AND THEIR DEPENDENCY ON OTHERS

Section I: Demographic profile of participants. Please check all that applies to you.
1. Place a check to what GENDER you are.
   1) ___ Male 2) ___ Female

2. Place a check to the AGE RANGE you fall in.
   1) ___ 19 and under 2) ___ 20-29 3) ___ 30-39
   4) ___ 40-49 5) ___ 50-59 6) ___ 60 and older

3. Place a check to what is your current RELATIONSHIP status.
   1) ___ Never Married 2) ___ Engaged 3) ___ Married 4) ___ Separated
   5) ___ Divorced 6) ___ Co-habiting 7) ___ Widowed

4. Are you currently EMPLOYED?
   1) ___ Yes 2) ___ No

5. Have you been diagnosed with a MENTAL HEALTH DISORDER?
   1) ___ Yes 2) ___ No

6. Which of the following MENTAL HEALTH DISORDERS are you diagnosed with and currently being treated for by a doctor?
   1) ___ Anxiety 2) ___ Bipolar 3) ___ Depression
   4) ___ Schizophrenia 5) ___ Other

7. How LONG have you been diagnosed with your mental health disorder?

<table>
<thead>
<tr>
<th>Recently</th>
<th>About 6 months to a year</th>
<th>A year or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Bipolar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Schizophrenia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX A

(continued)

Section II: How much do you agree with the following statements? Write the appropriate number (1 thru 4) in the blank space in front of each statement on the questionnaire.

4 = I totally agree  3 = I agree  2 = I disagree  1 = I totally disagree

Emotional reliance on others:

____ 8. I do my best work when I know it will be appreciated.
____ 9. I believe people could do a lot more for me if they wanted to.
____ 10. I would be completely lost if I didn’t have someone special.

Assessing self-confidence:

____ 11. I would rather be a follower than a leader.
____ 12. It is hard for me to ask someone for a favor.
____ 13. In an argument, I give in easily.

Assertion of autonomy:

____ 14. I prefer to be by myself.
____ 15. I don’t need other people to make me feel good.
____ 16. When I am sick, I prefer my friends to leave me alone.

STOP HERE. THANK YOU FOR PARTICIPATING.
APPENDIX B

SPSS PROGRAM ANALYSIS

TITLE 'African American Men and Women - Mental Health Disorders'.
SUBTITLE 'Robert A Woods'.

DATA LIST FIXED/
ID 1-3
GENDER 4
AGEGRP 5
RELATION 6
EMPLOY 7
DIAGNOS 8
DISORDE 9
HOWLONG 10
ERBEST 11
ERPEOPL 12
ERLOST 13
LCWOULD 14
LCHARD 15
LCGIVE 16
AAPREF 17
AADONT 18
AASICK 19.

COMPUTE EMOTION = (ERBEST+ERPEOPL+ERLOST)/3.
COMPUTE CONFIDE = (LCWOULD+LCHARD+LCGIVE)/3.
COMPUTE AUTONMY = (AAPREF+AADONT+AASICK)/3.
COMPUTE DEPEND = EMOTION+CONFIDE-AUTONMY.

VARIABLE LABELS
ID 'Case Number'
GENDER 'Q1 Gender'
AGEGRP 'Q2 Age Range'
RELATION 'Q3 Current Relationship'
EMPLOY 'Q4 Are you currently employed'
DIAGNOS 'Q5 Have you been diagnosed with a mental health disorder'
DISORDE 'Q6 Which mental health disorder are you diagnosed'
HOWLONG 'Q7 How long have you been diagnosed'
ERBEST 'Q8 I do my best work when I know it will be appreciated'
ERPEOPL 'Q9 I believe people could do a lot more for me if they wanted to'
ERLOST 'Q10 I would be completely lost if I did not have someone special'
LCWOULD 'Q11 I would rather be a follower than a leader'
LCHARD 'Q12 It is hard for me to ask someone for a favor'
LCGIVE 'Q13 In an argument I give in easily'

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APPENDIX B

(continued)

AAPREF 'Q14 I prefer to be by myself'
AADONT 'Q15 I do not need other people to make me feel good'
AASICK 'Q16 When I am sick I prefer my friends to leave me alone'.

VALUE LABELS
GENDER
1 'Male'
2 'Female/
AGEGRP
1 '19 under'
2 '20-29'
3 '30-39'
4 '40-49'
5 '50-59'
6 '60 up'/
RELATION
1 'Never married'
2 'Engaged'
3 'Married'
4 'Separated'
5 'Divorced'
6 'Co-habiting'
7 'Widowed'/
EMPLOY
1 'Yes'
2 'No'/
DIAGNOS
1 'Yes'
2 'No'/
DISORDE
1 'Anxiety'
2 'Bipolar'
3 'Depression'
4 'Schizophrenia'
5 'Other'/
HOWLONG
1 'Recently'
2 'About 6mos-year'
3 'A year or more'/
ERBEST
1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'/

ERPEOPLE
1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'/

ERLOST
1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'/

LCWOULD
1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'/

LCHARD
1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'/

LCGIVE
1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'/

AAPREF
1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'/

AADONT
1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'/

AASICK
APPENDIX B

(continued)

1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'/
EMOTION
1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'/
CONFIDE
1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'/
AUTONMY
1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'/
DEPEND
1 'I totally disagree'
2 'I disagree'
3 'I agree'
4 'I totally agree'./

RECODE ERBEST ERPEOPL ERLOST (1 THRU 2.99=2) (3 THRU 4.99=3).
RECODE LCWOULD LCHARD LCGIVE (1 THRU 2.99=2) (3 THRU 4.99=3).
RECODE AAPREF AADONT AASICK (1 THRU 2.99=2) (3 THRU 4.99=3).
RECODE EMOTION CONFIDE AUTONMY (1 THRU 2.99=2) (3 THRU 4.99=3).
RECODE DEPEND (.66 THRU 3.00=2) (3.01 THRU 5.99=3).

MISSING VALUES
GENDER AGE GRP RELATION EMPLOY DIAGNOS DISORDE HOWLONG
ERBEST ERPEOPL ERLOST LCWOULD LCHARD LCGIVE AAPREF AADONT
AASICK EMOTION CONFIDE AUTONMY DEPEND (0).

BEGIN DATA
0011512143434312142
0021212153434323211
0031352143141123431
APPENDIX B

(continued)

0041512143423223111
0051312113343223313
006141214343134122
0071311143423132343
008121214333121312
0091512133243333
010141213113211133
01115321334214111
0121312123311432343
0131512143444132311
0141512123434244431
0151312143334133222
01615111434322221
017151214333112144
018161113444444444
0191332133222121132
0201412143321233443
021131214342424333
02214621233422333
0232352123421132344
02423121333222233
0252512123324111111
02623121342242442
027246213343333443
028245214333132111
029231115344444444
0302422112431142423
0312612143311222322
032241211233113233
033255213322222222
034257213221123343
035231213341141111
036244211312232232
037245123441111211
038245213341134444
0392412123444142443
0402412112241433434
0412531143432433344
0422672133421432424
0432422112431143443
APPENDIX B

(continued)

0442261132233432134
0452672113432313143
0462412123434433334
047241213332132212
0481332111332113111
0491571153331121342
0501311153323141433
END DATA.

FREQUENCIES
/VARIABLE GENDER AGEGRP RELATION EMPLOY DIAGNOS DISORDE
HOWLONG ERBEST ERPEOPLE ERLOST LCWOULD LCHARD LCGIVE AAPREF
AADONT AASICK EMOTION CONFIDE AUTONMY DEPEND
/STATISTICS = DEFAULT.
APPENDIX C
IRB Approval Letter

CLARK ATLANTA UNIVERSITY
Institutional Review Board
Office of Sponsored Programs

November 14, 2010

Mr. Robert A. Woods <Robert.Woods@student.cau.edu>
School of Social Work
Clark Atlanta University
Atlanta, GA 30314

RE: A Study Comparing African-Americans Men and Women with Mental Health Disorder and Their Dependency on Others.

Principal Investigator(s): Robert A. Woods

Human Subjects Code Number: HR2010-10-363-2

Dear Mr. Woods:

The Human Subjects Committee of the Institutional Review Board (IRB) has reviewed your protocol and approved of it as exempt in accordance with 45 CFR 46.101(b)(2).

Your Protocol Approval Code is HR2010-10-363-1/A

This permit will expire on October 27, 2011. Thereafter, continued approval is contingent upon the annual submission of a renewal form to this office.

The CAU IRB acknowledges your timely completion of the CITI IRB Training in Protection of Human Subjects – "Social and Behavioral Sciences Track". Your certification is valid for two years (9/2012).

If you have any questions, please contact Dr. Georgianna Bolden at the Office of Sponsored Programs (404) 880-6979 or Dr. Paul I. Musey, (404) 880-6829.

Sincerely:

Paul I. Musey, Ph.D.
Chair
IRB: Human Subjects Committee

cc. Office of Sponsored Programs, "Dr. Georgianna Bolden" <gbolden@cau.edu>
"Dr. Sandra Foster <sfoster@cau.edu>

223 James P. Brawley Drive, S.W. * ATLANTA, GA 30314-4391 * (404) 880-8000

* Formed in 1988 by consolidation of Atlanta University, 1865 and Clark College, 1869
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APPENDIX D

Informed Consent Form

**Title of Research:** A Study Comparing African-American Men and Women with a Mental Health Disorder and Their Dependency on Others

**Investigator:** Robert A. Woods, Social Work Major Student at Clark Atlanta University

**Explanation of Procedures**
You are being asked to participate in a research project to see how much you depend on other people as you live with your mental health disorder. You will be asked to complete a questionnaire with only 16 questions which should take no more that 15 minutes of your time.

**Risks**
There will be no risk or physical harm toward you for participating. This study will not affect any disability benefits or current medical treatment you are receiving. Your participation in this study is strictly voluntary. You may refuse to participate and at any time withdraw from participating in this study.

**Benefits**
The benefit for participating in this research will help to develop new strategies and interventions to help mental health clients.

**Confidentiality**
All information gathered from the study will remain confidential. Your identity as a participant will not be disclosed to any unauthorized persons; only the researchers and Clark Atlanta University Institutional Review Board (the committee that approved this research project) will have access to this study, which will be kept in a locked drawer.

**Costs and/or Payments to Subject for Participation in Research**
There is no cost to participate and you will not be paid to participate.

**Questions**
If you have any questions please feel free to contact Robert A. Woods through email rawoods66@yahoo.com or Dr. Sandra J. Foster, Research Advisor at (404) 880-8774.

Please Initial One:

___ I AGREE TO PARTICIPATE
___ I DO NOT AGREE TO PARTICIPATE

If you agree to participate you will receive a copy of this informed consent.

<table>
<thead>
<tr>
<th>Print Your Name</th>
<th>Sign Your Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Researcher</td>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES


criticism, family contact, and consumer clinical and psychosocial functioning for African-American consumers with schizophrenia. *Community Mental Health Journal.* 45(2), 106-16.


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