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African American Women's Beliefs, Coping Behaviors, and Barriers to Seeking Mental Health Services

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Abstract

Little is known about African American women's beliefs about mental illness. In this qualitative study we employed the Common Sense Model (CSM) to examine African American women's beliefs about mental illness, coping behaviors, barriers to treatment seeking, and variations in beliefs, coping, and barriers associated with aging. Fifteen community-dwelling African American women participated in individual interviews. Dimensional analysis, guided by the CSM, showed that participants believed general, culturally specific, and age-related factors can cause mental illness. They believed mental illness is chronic, with negative health outcomes. Participants endorsed the use of prayer and counseling as coping strategies, but were ambivalent about the use of medications. Treatment-seeking barriers included poor access to care, stigma, and lack of awareness of mental illness. Few age differences were found in beliefs, coping behaviors, and barriers. Practice and research implications are discussed.

Keywords

African Americans; coping and adaptation; dimensional analysis; mental health and illness; stigma; women's health

In 2000 there were 34.7 million African Americans in the United States, making up approximately 13% of the population (U.S. Census Bureau, 2002). Unfortunately, almost 25% —or 7.5 million—African Americans have been diagnosed with a mental illness (Davis, 2005). African American women might be overrepresented in this population as they are at a higher risk for developing mental illness. Risk factors include lower income, poor health, multiple role strain, and the “double minority status” of race and gender (Neufeld, Harrison, Steward, & Hughes, 2008; Schneider, Hitlan, & Radhakrishnan, 2000). Older African American women might be at an additional risk because of the high prevalence of chronic disease in this population, and the demonstrated correlations between chronic disease and mental health issues such as depression (Artinian, Washington, Flack, Hockman, & Jen, 2006; Centers for Disease Control and Prevention, 2004).

A national study conducted by the California Black Women's Health Project (2003) revealed that 60% of African American women experience symptoms of depression. Even so, the use of outpatient mental health services is lower for African American women compared to White women and African American men (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler,

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2005; Mays, Caldwell, & Jackson, 1996; U.S. Department of Health and Human Services [DHHS], 2001). Another study examined treatment seeking among adult African American women with panic disorders, and found that only 13% sought treatment (Neal-Barnett & Crowther, 2000). Low rates of service use also hold true for older African American women. Matthews and Hughes (2001) found African American women over age 50 were less likely to participate in therapy than those under age 50.

To date, little research has examined how individual beliefs and attitudes influence coping behaviors and treatment seeking specific to African American women (Mays et al., 1996). Qualitative studies based on a comprehensive theoretical framework are virtually nonexistent and critically needed (Moodley, 2000). To address this gap, we employed the Common Sense Model (CSM) to guide us as we queried African American women's beliefs about mental illness, their coping behaviors in response to mental illness, and the barriers to their seeking mental health services. We also examined whether beliefs and coping behaviors varied by age.

Literature Review

Attitudes and Beliefs About Mental Illness

Events like the Tuskegee Experiments (Rusert, 2009) are hypothesized as contributing to many African Americans' negative attitudes about seeking health care services. For African Americans, sociopolitical history might play a large role in fostering cultural mistrust toward the United States health care system (Whaley, 2001). Cultural mistrust is defined as “paranoia, in the form of mistrust, of whites due to past and present experiences with racism and oppression” (Terrell & Terrell, 1981). High levels of cultural mistrust have been associated with mental illness stigma in the African American community. Stigmas are cues that elicit stereotypes about a particular social group (Corrigan, 2000). These stereotypes are manifested in people's attitudinal responses to individuals with mental illness. A study conducted in the early 1980s found that African Americans held more negative attitudes toward individuals with mental illness compared to other racial and ethnic groups (Silva de Crane & Spielberger, 1981). Research by Diala and colleagues (2000) found that attitudes have not changed: African Americans are still more likely than Whites to have shameful attitudes about friends who have sought help for a mental health problem. Furthermore, the shame about having a mental illness can result in treatment avoidance (Alvidrez, 1999; Sirey et al., 2001).

Despite the growing body of literature on stigma and mental illness, little has addressed adult or older adult African American women's experiences. Most research tends to be gender neutral, meaning that specific information about each gender is not provided. In addition, current research has failed to examine the influence of stigma on attitudes about mental illness and treatment-seeking behaviors specific to African American women. Examination of stigma, mental illness, and treatment-seeking behaviors among older African American women is virtually nonexistent. These gaps in current research limit opportunities to develop culture-, gender-, and age-specific interventions to reduce stigma and increase treatment-seeking behaviors among young, middle-aged, and older African American women.

Coping With Mental Illness

Lazarus and Folkman (1984) defined coping as “the constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as stressful or exceeding the individual's resources.” These efforts range from seeking professional help to ignoring the problem. The treatment-seeking literature suggests that African Americans tend to cope with mental health problems by using informal resources such as the church, family, friends, neighbors, and coworkers (Matthews & Hughes, 2001). Jackson, Neighbors, and Gurin (1986) noted that African Americans sought services as a result of

referrals by family members, and tended to seek treatment from ministers and physicians as opposed to mental health professionals. In a study conducted by Yick (2008), culturally diverse women who survived domestic violence used religion and spirituality to cope with the effects of abuse.

Use of informal coping mechanisms (family, friends, and church) is frequent among African American women (Abrams, Dornig, & Curran, 2009). Alvidrez (1999) found that African American women, compared to White women, held stronger beliefs that family problems should not be discussed outside of the family. Neighbors, Musick, and Williams (1998) found that African American women were more likely to seek help from ministers; if a minister was contacted first, the likelihood of seeking help from other sources was decreased. Cultural beliefs appear to affect coping behaviors, as well. In particular, the stress and anxiety of maintaining an image reinforced by the cultural community can have deleterious effects on coping behaviors and health (Neal-Barnett & Crowther, 2000), such as in the case of the cultural stereotype of the strong Black woman. Maintaining the image of the self-reliant Black woman might delay or hinder treatment seeking among African American women (Matthews, Nelesen, & Dimsdale, 2005; Mays et al., 1996).

Although the research described above has provided insight into coping strategies used by African American women, and might explain why African American women evidence low mental health service use, most of these studies were conducted in the 1980s and 1990s, and thus the findings are dated. In addition, the samples in those studies did not include older African American women (65 years and older), thus providing no information about how older African American women cope with mental illness.

Barriers to Seeking Treatment for Mental Illness

Recent studies highlight many barriers that impede treatment seeking among African Americans. Cristancho and colleagues created a vulnerability model that outlined the interaction of two types of barriers: (a) system-level barriers—those that are created by systems designed to provide mental health service, and (b) individual-level barriers—how individuals view and experience their encounters with the system (interpersonal and intrapersonal; Cristancho, Garces, Peters, & Mueller, 2008; see also Neufeld et al., 2008). Among the barriers, stigma has been identified as the most significant (DHHS, 2001) because it is both a system- and individual-level barrier. Other system-level barriers include access issues (inaccessible location, transportation problems, and lack of health insurance), availability of services (few opportunities for group counseling and in-home services), social issues (lack of child care), poor quality of care (limited access to culturally competent clinicians and case management), and cultural matching (few opportunities to work with racial and ethnic minority clinicians; Cristancho et al., 2008; Miranda et al., 2003; Tidwell, 2004).

Although the growing body of literature on systemic-level barriers makes a significant contribution, it fails to provide insight into whether other beliefs (individual level)—such as internalized stigma of mental illness, shame and embarrassment about mental illness, lack of knowledge of mental illness and cultural norms—might serve as barriers for African American women. Also, little research has assessed the individual-level barriers experienced by older African American women. For example, it is possible that the interaction between negative stereotypes of aging and the stigma of mental illness might exacerbate barriers for older African American women.

In sum, African Americans hold negative attitudes toward seeking mental health care. Stigma associated with mental illness and treatment seeking is prevalent among African Americans; they tend to cope with mental illness through informal support networks (family, friends, church leaders), and experience numerous barriers when seeking treatment. It is also important

to note that most of the research in these areas is dated and does not address the specific issues of African American women in general, and older African American women in particular. To address these research gaps, a qualitative study using the Common Sense Model (CSM) seemed most appropriate. The CSM, which focuses on beliefs that are intrapersonal in nature, provides a theoretical framework to examine beliefs and coping behaviors from the perspective of African American women, thus giving value to their voices.

Theoretical Framework

Common Sense Model

The Common Sense Model (CSM) postulates that individuals use common sense beliefs to construct lay theories, called *representations* of health threats or illnesses. These representations are based on ideas, attitudes, and beliefs formed by experience, cultural traditions, formal education, and stories from family and friends (Diefenbach & Leventhal, 1996; Donovan et al., 2007; Ward, 1993). Representations, or beliefs, guide the manner in which individuals cope with health threats and illnesses (Petrie, Jago, & Devcich, 2007). The CSM has been used in studies involving chronic fatigue syndrome, myocardial infarction, diabetes mellitus, HIV/AIDS, and rheumatoid arthritis to examine perceptions of illness and how people cope (Hagger & Orbell, 2003). More recently, use of the CSM has been extended to include mental illnesses such as schizophrenia, depression, and eating disorders (Fortune, Smith, & Garvey, 2005; Holliday, Wall, Treasure, & Weinman, 2005; Lobban & Barrowclough, 2005). These studies have supported the relationships between illness representations and symptom reporting, treatment seeking, behavior change, and adherence to treatment (MacInnes, 2005; Petrie et al., 2007).

The CSM incorporates seven key dimensions of illness representations: identity, cause, timeline, consequences, cure or controllability, illness coherence, and emotional representation. *Identity* focuses on beliefs about symptoms of an illness. *Cause* refers to beliefs about factors that cause the illness or are associated with illness onset. *Timeline* relates to beliefs about whether an illness is acute, chronic, or cyclic. *Consequence* refers to beliefs about the short- and long-term outcomes of the illness. *Cure or controllability* includes beliefs about the curability or controllability of the illness, and *illness coherence* involves the meaning of the illness to the individual. Finally, *emotional representation* refers to the emotional impact of and response to the illness.

Because of the manner in which representations are formed, illness representations might differ based on cultural background and age cohort. Furthermore, depending on the information source, the representations might or might not be medically accurate. Representations can influence how individuals cope with health threats; as a result, coping strategies are often employed in a manner consistent with the individual's representations of the illness. For example, it is possible that an African American woman who believes that living with psychological pain is commensurate with her role as a strong Black woman might not perceive her pain as a health threat or seek treatment. Also, among older African Americans, it is possible that depression might be dismissed as a normal part of aging because of negative stereotypes about aging.

To date, the CSM has not been used to study beliefs about mental illness in an African American population; however, its use with racial and ethnic minorities has been recommended (Diefenbach & Leventhal, 1996). Moodley (2000), in particular, states that “research which investigates the representations/beliefs of subjective psychological distress from black and ethnic minority groups will not only provide conceptual and theoretical knowledge, but offer therapeutic strategies to support present practice and future research” (p. 2). Building on the literature reporting low rates of mental health service use and high prevalence of stigma in the

African American community, the CSM can provide information about beliefs, attitudes, and coping behaviors, thus guiding the development of interventions tailored to this group. To this end, we examined the following research questions: (a) What are African American women's representations/beliefs about mental illness? (b) What are African American women's coping behaviors in response to mental illness? (c) What are the individual-level barriers (interpersonal and intrapersonal) to seeking mental health care among African American women? and (d) Are there age differences in representations, coping, and barriers among African American women?

Method

Study Design and Sample

Because this study is the first, to our knowledge, to use the CSM with an African American population, an exploratory descriptive qualitative design seemed most appropriate. Inclusion criteria for this study were intentionally broad to maximize recruitment. Recognizing that little research has focused on older African American women, and hypothesizing that beliefs, coping behaviors, and barriers might vary by age, we sought a sample of young, middle-aged, and older African American women. Thus, African American women aged 25 years and over were eligible for the study. In addition, these women were eligible regardless of history of mental illness, as we were interested in their beliefs rather than their lived experience with mental illness. Exclusion criteria included males and White, Latino, and Asian women.

Purposeful sampling procedures were used to recruit 15 African American women from three age groups (young, 25 to 45 years, $n = 5$; middle-aged, 46 to 65 years, $n = 5$; and older, 66 to 85 years, $n = 5$). Purposeful sampling allowed for inclusion of subgroups of women and comparisons among subgroups (Creswell, 2007). The median level of education was two years of college or technical school. Annual income ranged from $0 to $50,000, with a median of $20,000 to $30,000. More than half of the participants described their socioeconomic status as middle class (55%). Only 14 participants reported marital status: 4 were married or living with a partner, 5 had never married, 3 were widowed, and 2 were divorced. The mean number of children was three. More than 50% of the sample reported that they had been diagnosed with a mental illness (young, $n = 4$; middle-aged, $n = 2$, and older, $n = 2$). The most commonly reported mental illness diagnosis was depression ($n = 8$).

Procedures

African Americans historically have a low rate of participation in health research; thus several recruitment strategies were employed: (a) flyers were posted at community agencies including local African American churches, senior housing facilities, and community centers; (b) advertisements were published in a local African American magazine; (c) flyers were strategically posted around the local neighborhood and in businesses; and (d) meetings with pastors/leaders of local churches and directors of community agencies were set up to build community partnerships and promote the study. We also used a snowballing technique in which participants were encouraged to inform other women about the study.

The study was approved by the institutional review board (IRB) of a large university in the Midwestern United States. Written informed consent was waived; however, participants were given an information letter containing all of the elements of informed consent (i.e., purpose of the study, benefits, risks, confidentiality, the principal investigator's contact information, and IRB representative contact information). Participants gave only verbal consent, which reduced the possibility of linking participants to their data, thus further protecting confidentiality. To enhance comfort level and trust, participants were allowed to choose their interview location; some participants were interviewed in their home and others in the researcher's office. At the

end of the interview, participants completed a brief demographic questionnaire, which took about 5 minutes. The demographic questionnaire queried participants' ages, marital status, level of education, socioeconomic status, and income. In addition, two questions asked participants if they ever had a mental illness and, if so, what they did about it. To aid responses, a list of the more prevalent mental illnesses and coping mechanisms were provided in a checklist format. After completion of the interview and demographic questionnaire participants were invited to participate in a debriefing session, which was designed to give them an opportunity to process any emotional reactions to the interview, concerns about their participation, and referrals for mental health counseling, if needed. Only 1 woman participated in the debriefing session.

Interviews

All women participated in a 60- to 75-minute, semistructured, face-to-face interview designed to elicit candid beliefs, attitudes, and opinions about the issues of inquiry. The interview questions (see Table 1) were based on the CSM and focused on the seven dimensions: identity/symptoms, cause, timeline, consequences, cure/controllability, illness coherence, and emotional representation. All interviews were recorded and transcribed by a trained transcriptionist.

The interviews were conducted by the principal investigator (the first author), an experienced researcher and licensed psychologist. The use of a single interviewer was employed to ensure adherence to the study protocol and to reduce bias attributable to interviewer variability. The interviewer was a Black female with 9 years of active involvement in the community in which the data were collected; these factors, which we believe facilitated entry into the participants' worlds, provided a deeper understanding of their perspectives (Ward, 2005) and enhanced rapport and participant trust—all important issues when high levels of cultural mistrust might be present (Hamilton et al., 2006).

Data Analysis

Using the CSM, the data were analyzed with the goal of identifying the seven conceptual dimensions consistent with the CSM. Dimensional analysis was employed, involving constant comparative analysis, with the goal of integrating the data to better understand “what all is involved here?” (Schatzman, 1991, p. 310). The following analytic strategies were employed: line-by-line analysis of transcripts to facilitate open coding, memo writing, constant comparative analysis, saturation of emerging dimensions, and integration of the emerging dimensions (Charmaz, 2000; Kools, McCarthy, Durham, & Robrecht, 1996; Schatzman, 1991).

Data analysis was conducted by a research team consisting of the first author, the second author (an advanced doctoral student in counseling psychology), and a doctoral student in nursing. Each team member was Black, female, and actively involved in the African American community for at least 5 years prior to working on this study. Each team member independently conducted open coding, then met as a team to address discrepancies in coding. Differences were resolved by consensus. Thereafter, the team met weekly to review memos, conduct constant comparative analysis, and integrate the data. Below is a description of the data analysis procedures.

Phase one was open coding, which involved identifying salient emerging dimensions, properties, and conditions. Salience was determined by language expression such as phrasing, repetition, and description of meaningful actions and events. Dimensions were based on the CSM (e.g., identity, cause, consequences, and so forth). Properties were descriptors of the dimensions (e.g., trauma, stress, or biology, as related to the cause dimension). Conditions

influenced an action (e.g., barriers are a condition). Open coding was conducted by uploading the transcripts into NVivo, a qualitative computer software program that facilitates data coding, rapid retrieval and comparison of codes, and data management (Richards, 2006).

Phase two was memo writing, which involved recording stages of the analysis. Memos were used to decipher and expand dimensions to identify properties and conditions, and also to identify interrelations among dimensions, properties, and conditions (Charmaz, 2000; Glaser & Strauss, 1967). For example, one memo focused on the cause dimension and identified three properties/descriptors that participants believed caused mental illness: general, culturally specific, and age-related.

Phase three was constant comparative analysis. Dimensions identified in phases one and two were compared across individual participants to better understand the individual dimensions, as well as the similarities, differences, and interrelations among dimensions (Bowers, 1989; Glaser & Strauss, 1967). In phase four, analysis continued until saturation, or the “point in which the researcher cannot discover new dimensions in the data being collected,” was achieved (Bowers, 1989, p.48). In phase five, the data were integrated by combining the dimensions, properties, and conditions into a whole in an effort to understand “what all is involved here” (Schatzman, 1991, p. 310).

At analysis completion, the results section of the manuscript was given to two participants to conduct member checking (Lincoln & Guba, 1985). These women were selected because they explicitly expressed an interest in maintaining a research-related relationship with the principal investigator, and offered to participate in future research opportunities; one was a middle-aged woman with some college education, and the second was a retired high school teacher. The two women were instructed to review the results, and both indicated that their experiences were accurately captured.

Results

The three subgroups of participants differed in education level, income, and mental health diagnoses. Participants in the young age group (25 to 45 years) were less educated, reported lower incomes, and had the highest average number of children. They were also more likely to report a history of a mental health diagnosis, the most prevalent being depression. Results are presented specific to each research question. The first question examined African American women's representations/beliefs about mental illness.

Identity

Three categories of symptoms (identity) were identified in the data: behavioral, emotional, and cognitive. Behavioral symptoms included irrational, bizarre, violent, and suicidal behaviors; sleep problems; and difficulty keeping a job. Emotional symptoms included excessive crying, extreme reactions to events and situations, emotional instability, and signs of depression and posttraumatic stress disorder. Cognitive problems were described as distorting reality, mental disturbance, and difficulty solving problems and making decisions. Below are three quotes illustrating participants' beliefs about symptoms of mental illness:

> A lot of people get into real binds. I think their physical health suffers, I think their relationships with other people suffers. I think sometimes you find that those are the people who can't keep jobs, or have difficulty in jobs, or have problems with relationships. (Older woman)
>
> And now, me being [age] and faced with depression for like three years now, it's totally different to me, because I'm doing irrational things, things that I can't control

> myself. Like, constantly crying, and I don't know why I'm crying, and waking up in the morning, just crying for no reason. (Young woman)
>
> [One] who acts out either subconsciously, unconsciously, unintentionally … actions and thoughts that are different from what the expected norm is. (Older woman)

Cause

Causes of mental illness were categorized as 3 types: general, culturally specific, and age related. Table 2 presents descriptors (properties) of general causal factors, which included trauma, stress, biology or genetics, alcohol and other drug abuse, social relationships, individual personality issues, environment, and triggers. The following quote illustrates participants' beliefs about general causal factors:

> It's a wide range of causal issues. I think that some of it might be the simple stress of living, all the way to the extreme of perhaps some genetic defect, or some familial proclivity toward mental illness. Things like substance abuse, and even poor nutrition, I think, could cause mental illness. So I think there's a whole range of issues that can cause mental illness. (Middle-aged woman)

Culturally specific causes included social issues and psychological problems. Social issues included racism, discrimination, dual discrimination (race and gender), oppression, injustice, and daily stress and hassles related to being Black. Psychological problems were perceived as low self-esteem resulting from racism, dual discrimination, and historical oppression. The women's beliefs about culturally specific causes are captured in the following quotes:

> I think probably for African Americans in general, it's the stress of living in a racist society. (Middle-aged woman)
>
> But um, I think sometimes it [mental illness] happens with Black people who have been in um totally Black situations and then have to cope with a White situation. (Middle-aged woman)
>
> It [mental illness] could also be from some of the issues that's in society, stereotypes, uh racial stereotypes and things like that. (Young woman)
>
> There is a difference, I am quite sure. You have people in different communities, that's not African American that have, you know, centers where they can get help, those kind of services you know! And they are aware of them; they know where to go and how, you know, how to go about getting those services. (Young woman)

Women over 65 described two age-related causes of mental illness, illustrated in the following comment:

> I've been busy and you're supposed to keep your mind busy, as well as your body, too. I'm sure there's a lot of retired people who don't do [anything]. They just stop working, they stop thinking, they stop learning, they stop everything. Then you have plenty of idle time to go into depression. (Older woman)

Timeline and Consequences

Participants believed mental illness is a chronic health problem with symptoms of a cyclical nature, and that it can result in negative consequences including behavioral problems, institutionalization (including inpatient care or incarceration), homelessness, cognitive problems, physical health problems, and stigmatization by society and the mental health system. Below are two quotes illustrating beliefs about chronicity and negative consequences:

> From what I've seen, I think it can get better, but in the long term, I think they might not die from mental illness but they will still have it. They will still have those

> problems when they die. But I have not seen it that far, [but I] think that they can never overcome it. It will always be a struggle for them. (Middle-aged woman)
>
> Coming from where I came from, that's what I saw: African American females as well as males being institutionalized, because when you don't know what's wrong with them, the simple thing to do with them is to lock them up. You just have a mental problem, let's treat them [but instead they] lock them up sometimes in jail. I believe there's a lot of people in prisons that need mental help! (Young woman)

Cure/Control

Participants believed mental illness can be controlled with treatment, specifically individual and group counseling. They were, however, ambivalent and apprehensive about the use of medication to control mental illness. In particular, the women believed that use of medication could result in negative health outcomes including over-medication, side effects, and addiction. The women's support of counseling and concerns about medication are captured in the following participant comments:

> This doc [doctor], he don't understand, he just wanted to give them medication for this, he just want to give them medication for that.… When she really probably just needs support. When she probably needs a therapist, she probably needs a women's support group. (Young woman)
>
> I've seen what medication for mental illness does to a person, and I don't think it makes them themselves, it appears to make them like zombies. It's like brain-washing, or that's what it seems like to me. That's why I don't care for it. (Middle-aged woman)

Illness Coherence and Emotional Representation

The women's understanding of mental illness (illness coherence) appeared to be influenced by their culture. They reported that Blacks are supposed to be strong. However, being strong was accomplished by denying mental illness and, at times, viewing mental illness as a normal part of life. The participants reported that they were able to recognize when someone else has a mental illness, and were emotionally affected when seeing other people with mental illness. They reported experiencing a range of emotions on seeing someone with visible signs of mental illness, including empathy, sadness, compassion, and a desire to help. Participants also reported experiencing conflicting emotions such as empathy and hope for the individual, while at the same time blaming the affected individual. Below are three quotes that highlight these issues:

> Being African American, stubborn, “I don't need that. Those things don't happen to our people. We don't have any mental issues.” That's just a given thing. I guess because we have to be so strong in everything else, they figure that we're not inclined to have nervous breakdowns, and things like that, which we do. I mean, it's a lot of people sitting at home having nervous breakdowns and don't even know what they had. (Young woman)
>
> I never realized until I was in my late 20s that I did have mental problems. Because I always thought it was normal. Because I was raised around a bunch of what I thought were seemingly normal women. And I look at them now and they weren't so normal. (Young woman)
>
> I just really feel sorry for them. I feel sorry for them, and then there's something in my heart that says, “Is there something I could do for this person?” I just really feel sorry for them. (Middle-aged woman)

In summary, these women held beliefs about symptoms (identity), causes, duration (timeline), consequences, and controllability of mental illness. In addition, their understanding (illness

coherence) of mental illness appeared to be influenced by culture. They were also emotionally affected by mental illness (emotional representation).

Coping Responses to Mental Illness

Our second question examined African American women's coping behaviors in response to mental illness. The participants endorsed a range of coping responses such as seeking professional help; informal support from people in their support network or going to a community-oriented support group; religious coping, which involved talking to a pastor, praying, and reading their Bible; self-help such as reading, journaling, or having a positive attitude; and denial or avoidance of the problem. Women 65 years and older endorsed staying busy as a coping strategy, which involved regular exercise, volunteering, and staying physically and emotionally active. Following are quotes highlighting some of these coping responses:

> I was never able to get professional help, so I had to fight my way through. It can be a good thing in a way, but for most people, it's not good because everybody needs help. If they don't get some type of help, anything could happen. They could hurt themselves in a lot of ways, like committing suicide, and that's what professional help is out there for—to prevent that from happening. So I advise anybody, if they have a problem that can elevate, get help right away. Don't wait until something bad happens, or something tragic happens. (Professional help; older woman)

> For me, it has always been having women around to give me some perspective. Talking to them, and listening to them, even though I might not initially agree with them, but I need to have people around me that provide me that kind of input. (Informal support network; middle-aged woman)

> I had gone through something that I thought that I would never be able to handle. And my coping mechanism was prayer. (Religious coping; older woman)

> I do a journal and I look for three things at the end of my day: what is one thing I learned, if I helped somebody, and if something or somebody made me laugh. Those are the three important things for me. Also, a close family is important. It would be very important for my family to be there to help me through whatever the storm is. Yeah, family's important, and friends too. (Self-help; older woman)

> Sometimes I just don't do anything about it, I just let it pass. Yeah it does pass, and you expect it to. It might take a couple of days, but it passes. (Denial or avoidance; middle-aged woman)

> Yeah, I will call her an' say I'm coming over to work, you know. She's got blinds; I clean blinds you know; I vacuum down the drapes and stuff, you know.… So that's my therapy, you know. Basically, that's my psychiatrist. (Staying busy; older woman)

Barriers

The third question examined individual-level barriers (interpersonal and intrapersonal) to seeking mental health care among African American women. Both systemic- and individual-level barriers were identified in the data; however, individual-level barriers were more prevalent. The one systemic barrier identified was access, which included agency issues and socioeconomic issues. Individual barriers included lack of knowledge of where to seek mental health services, embarrassment about mental illness, negative cultural perception, discriminative actions toward people with mental illness, and lack of awareness—which included lack of education about mental illness and lack of knowledge of signs/symptoms of mental illness (see Table 3). The two quotes below capture participants' beliefs about systemic (access) and individual barriers (lack of education):

> A lot depends on if you're able to have access to treatment and if you're able to have access to early treatment; so, again, it gets back to the whole poverty issue. A lot of the systems that are set up in poor neighborhoods are overstretched; they don't have adequate resources. And so people can't go to get support. And, even for a lot of working people, their insurance covers “x” number of visits and if you have to go beyond that, you pay out of pocket. A lot of people simply don't have that ability to pay. (Older woman)

> The answer is education. A person may be aware that they have diabetes; a person may be aware they have heart disease. We spend a lot more time talking about heart disease and diabetes and cancer and this kind of thing. In our society we don't spend a lot of time talking about mental illness. (Middle-aged woman)

Age Variations

The fourth question explored age differences in representations, coping, and barriers among African American women. First, we examined age differences in representations. Of the seven dimensions of the CSM, cause was the only dimension in which age differences were observed. Compared to young and middle-aged women, women over 65 years of age believed that inactivity during retirement could lead to mental illness (see the quote immediately preceding “Timeline and Consequences”, p. 7).

Second, we examined age differences in coping. Women in the over-65 age group were the only participants to endorse exercise, physical activity, volunteering, and ongoing activity as important to coping. Below is a quote describing the older women's belief about exercise as a coping strategy:

> So exercise is good for mentally ill people. They hurt and hurt and hurt, even with medication they still hurt. ‘Cause that's the way I do mine; it works for me. There are different things for different people, I know that you know. But exercise would be good. (Older woman)

Thus, older women believed staying active and engaged were protective. No age differences were found pertaining to barriers.

Discussion

To our knowledge, this study is the first to use qualitative methodology combined with the Common Sense Model (CSM) theoretical framework to comprehensively examine African American women's beliefs about mental illness, coping behaviors in response to mental illness, and barriers to seeking treatment. Use of the CSM helped to illuminate underlying beliefs of participants. The findings from the present study provide a framework to better understand this group's conceptualization of mental illness, their coping mechanisms, and how stigma and other barriers affect treatment-seeking behaviors.

Beliefs About Mental Illness

The women believed that culturally specific factors (racism, discrimination, and oppression) can lead to depression. This supports an earlier study conducted by Ward and Heidrich (in press). Ward and Heidrich used an exploratory descriptive study to examine beliefs about mental illness among 185 African American women. Study results indicated that participants believed racism and discrimination cause depression. Several other investigators have supported these findings, as well (Cain & Kington, 2003; Williams & Williams-Morris, 2000).

The participants accurately identified consequences of mental illness; however, all consequences were negative and quite severe. Of particular concern is the belief that African Americans with mental illness are often hospitalized or sent to jail. Recent statistics from Wisconsin, the site of this study, supported these women's belief. In particular, recent research indicates significant disparities between African Americans and Whites in rates of hospitalization for mental illness. For instance, African American women receive inpatient care for bipolar disorder at a rate of 122 per 100,000 persons, compared to 44 per 100,000 for White women (Wisconsin Minority Health Program, 2004). Rates of incarceration among African Americans and Whites in Wisconsin are also disparate. Although African Americans make up only 6% of the population, they account for 48% of the prisoners in Wisconsin (Wilayto, 2000).

The women's beliefs about the identity or symptoms associated with mental illness and the course of the illness (timeline) were accurate and consistent with the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2001). However, some women reported a lack of awareness and, at times, denial of the existence of mental illness in the African American community, possibly influenced by cultural beliefs that Blacks are supposed to be strong or that mental illness is normal in the African American community. These beliefs could be related to the mental illness stigma in the African American community.

The women believed that mental illness can be treated with counseling (individual or group), yet, mainly because of side effects, they expressed ambivalence toward medication use. Their concern is supported by a recent study in which it was found that African Americans were more likely to be prescribed older, less tolerable, and less safe tricyclic antidepressants than Whites, who were significantly more likely to receive newer, safer, and more tolerable serotonin reuptake inhibitors (SSRIs) for depression (Melfi, Croghan, Hanna, & Robinson, 2000). Whether because of fear of side effects, insurance status, or mistrust in the health care organization, African Americans are less likely to fill prescriptions for antidepressant medications. A study by Ray, Hall, and Meador (2007) found that only 29% of African Americans fill a prescription, compared to 51% of Whites.

Coping Responses

The women endorsed a range of coping behaviors, including seeking professional help, using informal support networks, prayer, and avoidance. It is possible that the sole use of informal support networks or religious coping can result in adverse consequences, as they tend to delay treatment seeking. Consistent with previous research, the women preferred counseling to medication (Dwight-Johnson, Sherbourne, Liao, & Wells, 2001).

Barriers

Our finding of the perceived systemic barrier to treatment (access) is consistent with current research (DHHS, 2001). In particular, issues of access such as lack of health insurance, availability of services, and quality of care were underscored in the former Surgeon General's report addressing disparities in access to mental health care and the poor quality of care received by racial and ethnic minorities (DHHS, 2001). Using the CSM, most of the barriers identified appeared to be individual-level issues such as a lack of knowledge of where to seek mental health services, embarrassment about mental illness, normalizing mental illness, and discriminative actions toward people with mental illness. Further research on the individual-level barriers identified in this study is needed, with the goal of developing appropriate educational interventions.

Age Variation

Few age variations were found. Compared to young and middle-aged women, older women believed that inactivity during retirement could lead to mental illness, and that staying busy through regular exercise, physical activity, and volunteer work was an important coping strategy. A growing body of research suggests a positive link between physical activity and mental health among older individuals; those who are physically active show significant improvements in reasoning, working memory, reaction time (Clarkson-Smith & Hartley, 1989), postural control, reduced incidence of falls (Day et al., 2002), cognitive resilience (Hogan, 2005), and quality of life (Fontane, 1996).

Limitations and Implications for Future Research and Practice

The subsample within each group was small ($n = 5$), which might have reduced the possibility of identifying more age variations. Future research could expand the sample among young, middle-aged, and older participants to further examine age variations in beliefs, coping, and barriers to treatment seeking. The theoretical framework, the Common Sense Model, guided our interview questions and data analysis, and helped to illuminate underlying beliefs. Future research could combine the CSM with more general questions querying additional beliefs about mental illness and individual-level barriers. Based on our findings, research is needed to develop and evaluate effectiveness of interventions designed to increase awareness and treatment seeking while reducing stigma. Examples of such interventions are outreach programs/interventions using a psychoeducation format designed to educate individuals about mental illness, treatment options, and community resources that also address the misconceptions and stigma associated with mental illness and seeking treatment for mental illness. Such interventions and clinical intervention research could make a significant contribution to increasing treatment-seeking behaviors while reducing disparities in mental health and mental health care for this group.

Conclusion

As noted previously, we believe this study is the first to use qualitative methodology combined with the Common Sense Model theoretical framework to comprehensively examine African American women's beliefs about mental illness, coping behaviors in response to mental illness, and barriers to seeking treatment. Use of the CSM helped to illuminate participants' underlying beliefs. The findings provide a framework to better understand this group's conceptualization of mental illness, their coping mechanisms, and how stigma and other barriers affect treatment-seeking behaviors. Furthermore, these findings can serve to inform future research and the development of interventions designed to increase awareness of mental illness while reducing stigma, increase treatment-seeking behaviors, and increase the use of appropriate coping behaviors. These findings can also inform research and development of interventions for older African Americans women, with a focus on physical activity and mental health.

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Table 1

Interview Questions

Question	Dimension of the Common Sense Model
What does “mental illness” mean to you?	Illness coherence
What do you think causes mental illness?	Cause
What do you think are some signs that suggest a person is experiencing a mental illness?	Identity/symptoms
What do you think happens to people with mental illness?	Consequences
How do you feel when you see someone with a mental illness?	Emotional representation
Do you think people with mental illness can get better?	Cure/control & timeline
What do you think can help people with mental illness?	Cure/control
If you had a friend or family member with a mental illness, what would you tell them to do about it?	Cure/control

Table 2

Descriptors (Properties) of the General Factors Participants Believe Can Cause Mental Illness

General Causal Factors	Descriptors of the Causal Factors
Trauma	Childhood abuse, neglect, sexual abuse, loss of parent from death, divorce or separation
Stress	Work-related stress, financial stressors, general stress, and stress because of life events and situations
Biology	Genetics, heredity, and predisposition
Drugs	Use and abuse of alcohol and other drugs
Social relationships	Absent father, family problems, and peer pressure
Individual issues	Personality issues and low self-esteem
Environment	Neighborhood and home environment
Triggers	Past trauma, self-blaming, discrimination, and internalized racism

Table 3

Descriptors (Properties) of Barriers When Seeking Mental Health Services

Barriers	Descriptors
Systemic barriers	
Agency	Agencies not located in the African American community
	Access issues within the agency; “have to fight to get an appointment”
	Poor quality of care and culturally incompetent clinicians, which increases the risk of misdiagnosis
	Government unwilling to make genuine commitment to mental illness
Socioeconomic status	Cannot afford cost of services/no health insurance
	Poverty
	Low education
	Housing issues
	Unemployment
Individual barriers	
Knowledge of services	Don't know where to go
	Perception that the right kind of help (culturally sensitive) is not available
Embarrassment	Embarrassment about mental illness, seeking professional help, and taking medication for a mental illness
Cultural perception	Mental illness does not happen to African Americans
	You can “handle it” on your own
	“Strong woman syndrome”
	Silence and family secrets; “what happens in the family, stays in the family”
Discrimination	Feeling singled out and isolated
	You know when someone has a mental illness by the “the look”
	Stigmatizing attitude and discrimination
Lack of awareness about mental illness	Lack of education about mental illness
	Do not know signs, symptoms, and what type of treatment to seek