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Historically, African Americans have practiced self-concealment and utilized alternative forms of mental health treatment such as social support and religious mediation. Using Agnew's general strain theory and Link's labeling theory, I illustrate the potential role of cumulative stress and stigmatization in help-seeking behaviors of African American men and women. In addition to this theoretical approach, I conduct a mixed-methods analysis using the National Survey on Drug Use and Health's 2015 report and fifteen qualitative interviews from individuals who self-identify as experiencing symptoms of anxiety and/or depression. With these interviews, I identify six commonly-referenced themes mentioned by participants: identity struggle, stigmatization, distrust of medical providers, image maintenance, religious assumptions/ideologies and dismissal.

These themes lead to my defining of the lone survivor and consideration of its social, emotional and psychological implications.

LONE SURVIVOR: LINKING INSTITUTIONALIZED RACIAL ADVERSITY, LIVED EXPERIENCES AND MENTAL HEALTH CONDITIONS AMONG AFRICAN AMERICANS

by

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CHAPTER I

INTRODUCTION

Extant literature has noted the underuse of mental health services among minorities, most notably discussing potential reasons and implications regarding African Americans (Hays 2015, Watson & Hunter 2015, Ward & Heidrich 2009). As such, African Americans are substantially less likely to receive diagnoses and treatment compared to whites (Barksdale & Molock 2008). What is more, African Americans have suffered centuries of adversity (Baldwin 1984), which seemingly warrants psychological taxation.

For definitive purposes, mental illness is as a condition that affects a person's thinking, feeling or mood (NAMI 2016). In lieu of professional treatment for mental illness, African Americans have continuously practiced self-concealment and alternative forms of treatment, such as religious mediation, non-mental health professionals and family or friend support (Barksdale & Molock 2008, Earl et al 2011, Masuda et al 2012). In the present analysis, I propose to examine the reasons African Americans rely on these methods. Using general strain and labeling theory to conceptualize the presence, impact and coping strategies of mental illness among African Americans, I hypothesize that the rationale for foregoing treatment and/or engaging in informal coping practices prevail largely due to culturally relevant factors. These factors include, but are not limited to, conflicted societal and personal expectations of strength, mistrust of medical providers, and racialized stigma

of mental health, which have significant implications for African American mental health treatment. The data illustrates my concept of the Lone Survivor, how it is impacted by these factors and what this characterization means for those it includes.

In the following chapters I will examine mental health among African Americans more fully. Using quantitative data, I compare mental health experiences among a nationally representative sample of Black and non-Black US residents. Given the limitations of quantitative measures and data, I conduct fifteen qualitative interviews with African Americans who report experiencing anxious and/or depressive symptoms but refused treatment. In chapter two, I discuss the theoretical frameworks used in detail. Agnew's General Strain Theory and Link et al's Labeling Theory are used to depict the prospective influence of cumulative stress-related and stigmatization issues in the matter of mental health treatment. Chapter three provides a recent look in scholarly research involving African American's mental health concerns. In this chapter, I consider the sociological implications of mental illness, racial determinants, stigmatization, the racialization of stigmatization and the intersectionality of stigmatization. The fourth chapter will provide a detailed account of my mixed methods approach, including dataset selection, measurement techniques and qualitative strategy. In chapter five, I describe my quantitative analysis findings on the univariate, bivariate and multivariate level. Chapter six contains the qualitative findings; which are six, highly-mentioned themes which participants deemed influential in their deterrence from mental health treatment. Finally, I conclude by defining lone survivorship and discussing potential limitations.

CHAPTER II

THEORETICAL FRAMEWORK

Though mental illness is individualized in respect to daily lived experiences, it is certainly a sociological issue. Social complexities influence mental health onset, the interpretation of symptoms, and responses to mental health concerns. For example, a low-income African American woman's form of depression may not only differ from a low-income, white woman's depression, but also from a middle-class, African American woman's depression as well. In short, understanding mental health from a sociological perspective reveals the complexities of this issue. Below, I review two theoretical perspectives – general strain theory and labeling theory. While these theories were developed to explain "delinquent" outcomes, I use these theories to explain a particular "delinquent" condition -- African Americans' greater likelihood to hold mental health issues secret and/or their lesser likelihood to pursue formal, medical treatment when presented with mental health concerns.

General Strain Theory

General Strain Theory focuses on the individual and his or her social environment. The theory seeks to explain how strain is linked to various non-normative

outcomes through negative emotional[1] responses [to strain]. Agnew (1992) posits that strain in three ways – negative relationships with others, a lack of positive relationships with others and the presence of noxious stimuli. Below I discuss each of these in a bit more detail.

Prevention of Achieving Positively Valued Goals

Agnew conceptualizes three facets regarding the prevention of achieving positively valued goals: the disjunction between aspirations and actual achievements, the disjunction between expectations and actual achievements and the disjunction between just/fair outcomes and actual outcomes. Here, aspirations are defined as ideal goals, whereas expectations are anticipated and seemingly accessible goals. Just/fair outcomes refer to the expectation of fairness and equity.

Removal of Positively Valued Stimuli

Stress literature indicates that the notion of impending loss often yields criminogenic (for the purpose of this study, problematic) behavior in an effort to prevent

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[1] The use of Agnew's General Strain Theory is preferred to other social-psychological strain models. Specifically, Agnew's theory is rooted in the works of Merton; however, Agnew conceptualized three major types of strain (prevention of achieving positive goals, removal or threat to remove positively valued stimuli, presentation or threat to present of negatively valued stimuli) as compared to Merton's singular focus on prevention of achieving positively valued goals.

sudden change. Though not Merton's original consideration, a removal of positive stimuli could be analogous to the removal of individuals (e.g death, incarceration), removal of good health, or the loss of an important relationship

Presentation of Negatively Valued Stimuli

According to Agnew, the presentation of negative stimuli may lead to negative, often criminal outcomes. Such outcomes are attempted to be avoided through means of escape or avoidance of negative stimuli, termination of stimuli and/or revenge against source of stimuli.

General Strain Theory as Applicable to Race

Each of Agnew's components are applicable to race relations within the United States. Due to the social inequalities in America, whites are in a "better" position to block African Americans from acquiring positively valued goals. Moreover, given the historic discrimination and continued racism and isolation, African Americans are more likely to have exacerbated negative responses and a lack of access to gaining means by which to effectively positively cope with these negative responses to disproportionate strain. This dichotomy can cause stress in numerous ways: negative interactions, pressures to commit illegal or otherwise negative acts, encounters with legal institutions, etc. These relationships in turn can cause general stress that can translate to mental health concerns.

On the one hand, a lack of positive relationships often leaves individuals without strong sources of support, which mental health literature cites as a positive tool for coping with mental health conditions (Memon et al 2016; Umberson and Montez, 2010).

Without these sources, conditions may fester earlier, be sustained longer and yield more negative consequences, which can affect other aspects of life such as education, employment, and the like.

Noxious stimuli, on the other hand, are persons, objects and/or events which deter individuals from success. In the case of African American mental health, this may be compared to negative media portrayals of mental illness, stigmatization, negative family perceptions, and other previously mentioned culturally relevant factors. African Americans may seek to escape or avoid stigmatization (i.e. suffer in silence, seek treatment in secrecy), terminate stigmatization (i.e. denial of symptoms), seek revenge against the source of stigma (i.e. begin to advocate for social justice relating to persons with mental health disorders) and manage the resultant affect using illicit drugs (i.e. self-medicate).

I argue that African Americans confront each of Agnew's 3 identified strains. Given the persistence of systemic racialization and the negative economic, political and social consequence associated with racism, they are disproportionately blocked from obtaining commonly desired goals (e.g., socio-economic independence), they consistently have valuable human and social rights removed from them (e.g., segregation, isolation, and marginalization from desirable spatial and social arenas) they anticipate or

experience continued negative treatment (racism, discrimination, distrust, disenfranchisement).

My application above also relates to the development of relationships with others. As mentioned above, Agnew (1992, 2006) posits that strain-induced negative emotion can hinder participation in deviance *if* persons have access to pro-social coping strategies. Again, given our persistent, systemic racist social structure, African Americans are often barred or at least largely hindered from participating in society's white, dominant social sphere.

I argue, then, that in addition to African Americans encountering more strain, they are less likely to have access to the pro-social mechanisms that Agnew posits as crucial to maintain healthy, social beings. Specifically, African Americans are more likely to have negative relationships with [non-Black] others, have a lack of positive relationships with [non-Black, dominant] others and are consistently presented with racism and discrimination. Thus, we should expect that African-Americans are more likely to encounter negative emotions as a result. What is more, in the absence of access to intimate relationships with "conventional" others and self-efficacy, two of the pro-social coping strategies that Agnew acknowledges, I expect that African Americans will encounter self-imposed, culturally-imposed and structurally-imposed barriers to mental health treatment.

Labeling Theory

Labeling theory emerged in early Durkheimian literature pertaining to the act of naming certain crimes as illegal or deviant (Durkheim 1897). He found that defining crimes served not to uphold a penal code, but instead to outrage society. This outrage served to control the actions of others. Later used by Mead, Lemert and Becker, labeling theory has been applicable in countless subcultures such as homosexuality, atheism and mental illness.

Howard Becker's (1963) *Outsiders* has become one of the most well-known examples of labeling theory. Following unconventional groups, including marijuana users and dance musicians, Becker (1963) argued that deviance is not a characteristic of a bad person, it is a result of someone labeling an activity as such.

In his book, Becker (1963) notes the concept of "master status." A master status refers to the primary identifying characteristic of someone. Some examples of the master status include race/ethnicity, gender, sexual orientation and religion to name a few.

Becker used this notion to explain the label of delinquent as a master status, and it has since been used in other contexts (e.g., master statuses of offender, felon or inmate). In this proposed research, I follow the conclusion of Rosenhan (1973) and argue that one's diagnosed mental health disease serves as a master status. In other words, a person once identified as mentally ill is labeled as mentally ill forever and all subsequent actions are understood as being connected to that label.

Because [non-white] race may also be considered a master status, racial minorities are subjected to master status labels that highlight their minority racial

classification. This is especially true for African Americans given their historic exclusion in socio-political, socio-economic, and socio-cultural realms. The determination as mentally ill, especially conditions with increased severity, yield societal expectations of incompetence and disdain. Indeed, research finds that African American men diagnosed as mentally ill can now be considered "more" dangerous (Stickney et al. 2012) and African American women viewed as weak and/or crazy (Ward and Heidrich, 2009; Watson and Hunter, 2015; Wyatt 2004).

Link et al. (1989) developed a modified labeling theory to conceptualize the ways in which people react to a label. In short, their theory elaborates on the original labeling perspective in that it hypothesizes that people may manage labels in 3 different ways – they may keep the label secret, withdraw from social situations as a way to avoid interaction with others or participate in education about the presence and consequences of labels. Each method serves to protect oneself from discrimination, ridicule or another adverse effect of stigmatization.

Conclusion

As mentioned earlier, the diagnosis of a mental health condition can drastically alter a person's life, especially those already marginalized due to race. Using strain and labeling theory, the social-psychological toll of mental illness is ever present among African Americans, and should yield no surprise in reduced help-seeking behaviors.

CHAPTER III

LITERATURE REVIEW

Despite centuries of adversity, which arguably negatively influences mental health, African Americans have significantly lower diagnoses and are less commonly treated for mental health problems as compared to whites (Barksdale & Molock 2008). This chapter reviews the literature on issues surrounding mental health and African Americans. I begin by discussing sociological aspects of mental illness such as pervasiveness and demographics of those affected. Following, I discuss differences in presentation and representation between African American and white individuals in mental health diagnoses and treatment. In this section, I review some of the cultural reasons treatment may be avoided and self-concealment preferred among African Americans. Next, I review literature on stigmatization of mental health diagnoses and treatment, which includes negative perceptions of mental illness, its forms and the role of socialization in displays of vulnerability. To conclude, I will highlight the way in which the stigmatization of mental illness is racialized. This will consist of research discussing the public opinion of African American mental illness and the difficulty of diagnosis and treatment of African American mental health patients.

The Sociology of Mental Illness

Mental illness often affects one's ability to relate to others and carry out daily functioning. In terms of pervasiveness, approximately one in five adults (48 million people) suffer from a mental health condition each year (NAMI 2016). Dissecting by race, nearly 20 percent of Caucasian adults, 19 percent of African American adults, 16 percent of Hispanic and 14 percent of Asian adults suffer from a mental health condition (NAMI 2016). Although the prevalence of mental health illness differs across race and ethnicity, I am particularly interested in closely examining African American mental illness to alleviate strain in a population already underserved in all other aspects of life.

Race and Mental Illness

As stated above, national surveys indicate only about a 1 percent difference between Whites and African Americans in terms of mental illness experiences. In study of college-enrolled students, Barksdale and Molock (2008) found no racial difference in levels of stress among college students; however, they did find a significant racial difference in the treatment sought for mental illness. It should be noted that this does not indicate stress is a mental illness, though it is often a precursor to mental health symptoms. Others also find that African Americans have substantially lower rates of professional help-seeking behavior (Ayalon and Young 2005; Masuda et al. 2012).

Studies have attributed the cause to many potential factors such as poverty, lack of access to services and mistrust of provider in the underuse of mental health treatment

(e.g., Masuda et al 2012). These elements are repeatedly discussed due to individuals' inability to pay for mental health services, lack of suitable insurance coverage, reliable transportation and providers that recipients feel can be beneficial to their well-being.

In regard to help-seeking behaviors, African Americans are more likely to seek guidance from non-mental health care professionals, such as clergy, family and close friends (Masuda et al 2012 & Barksdale & Molock 2008). There is no definite reason for this discrepancy, but much of the literature favors culturally relevant factors and stigmatization (Dempsey et al 2015 & Watson & Hunter 2015). Culturally relevant factors include, but are not limited to, perceived family norms, need to conceal personal information, fear of treatment, fear of disclosure and vulnerability and unfavorable attitudes toward formal sources of help (Barksdale & Molock 2008). These factors may seem miniscule at first glance, but they are ingrained in the African American culture and are key elements of African American socialization. Beginning with perceived family norms, Barksdale and Molock (2008) discovered that the more negative the view of mental illness is in one's family, the less likely a member is to seek treatment. The perception of the family is highly considered when disclosing conditions and in help-seeking behaviors. There is, however, a gendered aspect to this, as girls are more influenced by family perceptions than boys are, potentially due to greater freedom men generally hold in society (Miller 2002).

Much literature describes the tendency of African Americans to mask mental health issues due to the threat of further stigmatization (Watson & Hunter 2015; Jones et

al 2015). The need to conceal potential mental health symptoms is closely related to fear of treatment, disclosure and vulnerability. Each of these factors refer to the traditional African American norm of keeping family business isolated to the home. Outside entities are not to know or be involved in family issues. Ward and Heidrich (2009) state that stigma related to mental illness is prevalent amongst those with and without mental health conditions. This alludes to the strength of stigmatization towards mental illness and its effect of concealment, treatment and self-concept. As an already marginalized and stigmatized group, it would seem absurd to seek out more stigmatization, which is what mental illness equates to in the African American community (Watson & Hunter 2015). Not only does greater society impose these negative perceptions, but within the African American family, stigma is used as a shaming agent as well.

Unfavorable attitudes toward formal sources of help can be viewed as a highly influential factor preventing African Americans from seeking mental health treatment. These attitudes are derived from centuries of adversity (Neighbors et al 2011), stigmatization (Earl 2011), accusations regarding the African American body (King & Wheelock 2007), the invisibility syndrome of African American men (Aymer 2010), the strong African American woman stereotype (Watson & Hunter 2015), cultural insensitivity from mental health professionals and general mistrust (Dempsey 2015 & Ayalon & Young 2005) to name a few. These gendered stigmatizations will be discussed in the intersectionality section.

In addition to disproportionate rates of African Americans seeking mental health treatment, minority clinicians appear at a deficit as well. As of 2013, The American Psychological Association (APA) identified only 5.3% of active psychologists as African American. This is compared to 83.6% Caucasian, 5% Hispanic, 4.3% Asian and 1.7% classified as "other" (APA 2015). Though racial match of clinician and client are not mandatory for effective mental health treatment, there is evidence that this may lead to higher rates of help-seeking behavior by allowing African Americans a sense of security and understanding which may not be immediately granted to clinicians of other ethnic groups (Carbral & Smith 2011). It is not rare for clients to feel judged, stereotyped and misunderstood when given clinicians from alternative reference groups (Aymer 2010, Earl 2011).

Indeed, when accounting for diagnosis and treatment, certain groups fare better than others. Adebimpe (1981) discussed the common occurrence of misdiagnosis among African Americans by Caucasian clinicians. Cultural incongruence and stereotyping make it difficult for clinicians to diagnose illnesses correctly and provide accurate treatment. For example, African American men often were labeled schizophrenic, when major depression would have been a more accurate identifier. Among African American patients, every action was calculated as a part of the diagnosis. Normal mannerisms that an African American clinician may understand as typical, such as a relaxed face, monotone voice, were interpreted as lack of communication and resistance to many white

clinicians. Symptoms of psychopathology were often exaggerated, leaving those African Americans with formal diagnoses, with very detrimental prospects (Becares et al 2014).

Due to skepticism of mental health practitioners, many African Americans seek counsel from clergy (Ayalon & Young 2005). Religion has historically served as a coping mechanism for African Americans. Religion has been central to providing hope to African Americans since they were first involuntarily migrated into the U.S. (Forsyth & Carter 2012). The Black church is a place of refuge, solace and setting for encouraging social change (Earl 2011, Barnes 2003). It should be expected, then, that religion and associated churches be used as a place of refuge for mental health crises as well. Though there are benefits to religious counsel (free treatment, familiarity with service provider and comfortability) (Dempsey 2015), there are drawbacks as well. For example, clergy are not subject to mental health counseling trainings of any kind. Also, given the context, most "therapy" will have religious undertones, which may contradict many issues people are facing such as homosexuality, adultery or suicidality. Religion can undoubtedly be a positive coping mechanism (through prayer, pastoral consultation, etc.) for some African Americans, but it may not suffice for all members of this population, particularly in regard to the illness being experienced.

Stigmatization of Mental Illness

Stigma is defined as a set of negative and often unfair beliefs that a society or group of people conceive about something. Regarding mental health, stigma is the

response that people have towards those with psychological disorders (Masuda et al 2012). Stigmatization may occur regardless of the mental health condition, though severity of the illness tends to evoke stronger rates of discrimination. Individuals with the label “mentally ill” are often scrutinized and viewed as “crazy” or “unstable”. In turn, these labels may distort the image of an individual to those around them, as well as the self-efficacy of said individual.

Those with a diagnosed mental disorder face a dual issue; the symptoms related to their mental health condition and the stigmatization that they because of their condition (Rusch 2014). This could potentially leave individuals to not only cope with their condition, but also internalize what that condition means to society and how it will affect their lives. Stigma not only affects initial disclosure and diagnosis, but treatment and the sustainment of treatment.

Rusch (2014) describes three main types of stigmatization: public, structural and self-stigma. Public stigma is defined as negative stereotypes and discrimination against those with a mental health condition. These are the beliefs most of society has, which in turn can affect education, employment, housing and general life satisfaction. Structural discrimination relates to societal perceptions of the “seriousness” of mental health and how it is funded as compared to physical health conditions. Not only is less research conducted for mental illness compared to physical diseases, but insurance companies do not value it the same either (Corrigan et al. 2014). This is indicated by providers being less likely to offer some kinds of health care services to clients with histories of mental illness.

Similar to extensive physical conditions, most mental conditions require continuous visits to therapists, psychiatrists, or other physicians. Without insurance coverage, mental health conditions are almost certain to remain untreated, especially within minorities. Corrigan (2014) details self-stigma, perhaps the most traumatic, is the internalization of negative stereotypes which may lead to shame, withdrawal and the demoralization of self. This can affect the self-concept, self-efficacy and overall life course.

Stickney (2012) makes note of stigmatization and its relation to social distance.

Social distance is defined as the willingness to engage in relationships of varying intimacy. He also makes mention of controllability, the control one has over their illness. There is an assumption made about those who seemingly have control over their issue, versus someone who does not. Control can be viewed here as liability. Those with control are viewed more negatively than those considered powerless over their condition. His study described the misconception that African Americans are "more involved" in the onset of their illness, versus Caucasian individuals having less "involvement", therefore received less stigma for their label. This racialized stigma is only one form of variation when it comes to racial, classist and gendered differences in mental health treatment.

These forms of discrimination, as well as other potential factors, contribute to the self-concealment of African Americans suffering from a mental health condition. Masuda (2012) defines self-concealment as the behavioral tendency to withhold distressing and potentially embarrassing personal information from others. In the next section, race will receive further mention.

Racialization of Stigmatization

As aforementioned, Masuda (2012) mentions the role stigma plays in the self-concealment of African Americans with mental health conditions. Studying college-enrolled students, Masuda et al. (2012) found that African American college students tend to have greater mental health stigma and less favorable help-seeking attitudes than their white counterparts. In translation, African Americans are more likely to participate in higher rates of self-concealment of mental health concerns due to stigma.

Given prior literature on mental illness and how African Americans disproportionately report mental health conditions, it follows that they may be less likely to receive medicalized treatment because of racism, stigma, and cultural incongruences as discussed in the above review. As such, African American individuals are more likely to suffer from mental illness in silence as compared to non-Black populations.

Intersectionality of Stigmatization

Intersectionality describes the multidimensionality of members apart of multiple minority groups. Coined by Kimberle Crenshaw (1989) and later utilized by Black feminist theorists, this term originally described the specific plight of African American women, who are marginalized by race and gender. Modernly, the term serves to describe oppressed members of multiple groups including race, gender, sexual orientation, religion, etc.

In regard to mental health, the intersectionality of race and gender has risen to the forefront of literature, specifically among African Americans. The particular experiences of women compared to men have sparked much debate on the causes, implications and solutions to gender specific issues among African Americans. Given that African American women are minorities in both race and gender classification, I will briefly provide a platform which to articulate the importance of mental health care to such a stigmatized population.

African American women are of distinct susceptibility to mental health concerns.

Historically, these women have struggled to negotiate numerous identities, the Strong Black Woman (Dow 2014, Thomas et al 2009), the Welfare Queen (Dow 2014), all in support of the African American male narrative (hooks 1992). Black feminist literature notes these identities as well as historical roles of African American womanhood, to depict the specific plight African American women survived in the perpetuation of white supremacy and the advancement of African American men (hooks 1992). Education literature notes that African American women experience higher rates of negative stereotypes, more frequent questioning of reliability, lack of institutional support and expectation to hierarchize racial to gender issues (Thomas et al 2009).

Research has aptly identified ways in which African American men are racially profiled by police and courts (Anderson 1999, Alexander 2011), discriminated against in the workplace (Watkins 2010) and experience daily microaggressions (Aymer 2010). These may influence or precipitate mental health concerns, but the stigmatization is

increased when the official label of mental illness is attached. Watkins et al. (2010) illustrate self-concealment as well in their study of African American men's mental well-being. Examining the reasons men remain silent, Watkins and her colleagues find that men are socialized to believe that asking for help is a sign of weakness and a threat to their masculinity. Among these men, masking behaviors (manners of speech, dress, walk, interpersonal tendencies, etc.) serve to disguise emotional distress and protect themselves from continued discrimination (Aymer 2010). Considering this, a sense of self-preservation can be depicted for African American men just as for women, however, often through different manifestations and causality.

Building upon the already evident stigmatization of the African American body, gender adds a new perspective when discussing mental health stigmatization. African American men, even when compared to African American women, face higher rates of stigmatization after receiving a mental health label (Watkins 2015). Some argue that African American men face more frequent and more severe forms of racism (DuBois 1903, Anderson 1999, Pittman 2011), which one could argue influences their susceptibility for a mental health condition. This population has also been socialized to separate themselves from weakness and readily display masculinity even when their health is concerned. It should not be surprising that most African American men, and women for that matter, participate in inpatient rather than outpatient mental health treatment (Ayalon and Young 2005). Due to sustained neglect or unawareness of illness, initial treatments do not occur symptoms are quite severe. Often, the individual is not

even aware that they are facing a mental health concern. They feel their symptoms are typical and disregard them as insignificant (Jang et al 2013). Again, mentioning masculinity, African American men tend to conceal emotional well-being for extended periods of time, utilizing general strain theory (Watkins et al 2010, Pittman 2011). Now race, adversity, gender, stigma and cumulative strain begin to weigh on the individual (Agnew 1992).

Conclusion

In conclusion, there is no definitive answer on why African Americans refrain from seeking treatment. There are numerous factors that each play a pivotal role, but it is impossible to deduce to a singular cause. With continued research, I hope to uncover a link between institutionalized racial adversity, lived experiences and mental health conditions in hopes of finding ways to better serve this underrepresented population.

CHAPTER IV

DATA AND METHODS

This study relies on a mixed method analysis. Below I discuss each component in more detail.

Quantitative Analysis

Quantitative analysis draws data from the 2015 National Survey of Drug Use and Health (NSDUH) data set. The NSDUH is a nationally representative survey collected annually among roughly 70,000 randomly selected individuals aged 12 and older. This dataset provides estimates on state-level and national drug use in aid of drug prevention and treatment initiatives.

Although the NSDUH is collected to gather information about trends of alcohol, tobacco and illicit drug use, it contains data on mental health. Given this and its sampling design, which provides a nationally representative sample of the non-institutionalized US population, I use it as a starting point to illustrate differences in mental health treatment among African Americans and non-Blacks. I conduct univariate, bivariate and multivariate analyses (through employing regression analysis) to examine whether race influences recent mental health treatment among adults who report experiencing mental health problems in the past year.

Measurements

My primary independent variable will be race, and my primary dependent variable is use of mental health treatment. Race was initially coded as a nominal level variable, indicating if the respondent was White, Black/African American, American Indian or Alaska Native, Native Hawaiian, other Pacific Islander, Asian, or a specified other category. Because I am interested in African American experiences, I recoded the race variable so that a code of 1 indicated African American and a code of 0 indicated any other race or ethnicity.

The mental health treatment variable that I use for the analysis includes 4 separate measures. These measures include whether or not the respondent reportedly received inpatient, outpatient, counseling or alternative treatments for mental health conditions in the past year. Because alternative treatments including informal means, such as consultations with a priest, nonclinical support person and/or other non-traditional medicines, I also created a second treatment scale that excluded this latter category.

These variables are called Treatment Scale 1 and Treatment Scale 2, respectively. I examine both in the subsequent analysis.

Given my research question, I examine the respondent's reported mental health condition. I measure the respondents' mental health condition using 12 separate items that gauge nervousness, hopelessness, restlessness, sadness, effort, feeling down, emotional problems going out, emotional problems socializing, trouble in work or school, suicidal ideations and attempts, discouragement, and loss of interest. I created a single

variable through a summation scale. The final mental health variable results in responses whereby higher numbers indicate increased severity of illness.[2]

I also include a control variable in the analysis -- the availability of insurance. The original insurance variable asked the respondent to report which, if any, type of insurance s/he had. I dummy-coded this measure into a yes/no response (yes=1; no=0).

Qualitative Component

In addition to this quantitative component, I conducted fifteen in-depth interviews of African Americans with a history of mental illness symptoms and no history of receiving medical treatment for such symptoms. Each participant was a self-identified African American adult who experiences or has experienced a mental health condition(s). Experiencing problematic mental health condition(s) can be illustrated in many ways, but I specifically recruited individuals who self-reported symptoms associated with depression and/or anxiety as identified by the recruitment materials and screening tools used throughout each interview (see Appendix A).

I used convenient, purposeful and snowball sampling to locate and identify potential participants in the qualitative portion of my research. Specifically, I (1) distributed recruitment flyers on the following Facebook groups webpages: UNCG Sociology Department, UNCG Black Lives Matter, UNCG Black Graduate Student

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[2] I created two mental health scales, one which included all of the measures discussed above and another that removed imputations from the scale. The descriptives across these two measures were virtually I identical, so I include only the more inclusive measure in all subsequent analysis.

Union, Neo Black Society UNCG, Black Girls and Women Matter Greensboro, and Mental Health Association in Greensboro, (2) utilized my personal Facebook account to announce and recruit for my research and (3) relied on respondent referral sampling to recruit eligible participants. Each of these means was approved by UNCG's Institutional Review Board.

Respondents provided consent to be interviewed (see Appendix B), with each interview lasting between twenty minutes and two hours. I conducted in-depth interviews to allow respondents to tell their own narrative. Interview questions focused on respondents' beliefs about mental illness in general, their own experiences with mental illness, their beliefs about the stigmatization of mental illness, beliefs about and experiences with racism, and beliefs about the racialization of mental illness. While I hoped that respondents will discuss these issues with relatively little probing, I constructed an interview guide to help structure each interview in light of my research question and the theories reported in Chapter 2 (see Appendix C). Following the interview, respondents were provided with a list of resources (see Appendix D) in case the interview sparked any unresolved emotion that the participant felt could best be accessed by a professional clinician.

CHAPTER V

QUANTITATIVE RESULTS

Descriptives

As shown by Table 1 below, approximately 13 percent of the NSDUH sample is African American. As mentioned in the earlier chapter, I calculated and examined 2 treatment scales. One included inpatient, outpatient, alternative forms of treatment and currently receiving treatment variables and the other included inpatient, outpatient and currently receiving treatment variables but removed alternative forms of treatment.

Although the mean response for treatment scales vary significantly (.22 versus .12), it should be noted that the modal response for both is 0, suggesting that most of the sample received no treatment in the past year. Nonetheless, given the substantial difference across these scales, I will examine both in the subsequent analysis. The large majority of respondents – 90 percent - have some form of insurance. Finally, the mean score for mental health status is around 4. As with the treatment variable, the modal response is 0, indicating no experiences with mental health conditions in the past year; however, responses range up to 27, which suggest frequent and multiple prevalence of mental health conditions in the past year.

Table 1. Descriptive Statistics (N=57,146)

Variable	Mean	SD	Range
Race (Black)	.13	.333	0-1
Treatment Scale 1	.22	.564	0-4
Treatment Scale 2	.12	.421	0-3
Insurance	.90	.306	0-1
MH Scale	4.19	4.721	0-27

Bivariate Relationships

The correlation matrix, which is presented below, indicates the strength, direction and statistical significance of all of my variables of interest. To remain consistent with the discipline, statistical significance is reported at the .05 level. As shown, race and treatment is statistically significantly and negatively correlated, suggesting that Blacks (coded 1) are less likely to report receiving treatment as compared to any other race (coded 0). his finding remains regardless of the treatment measure used (r = -.054 and r = -.039). This finding is also consistent with my hypothesis and prior research suggesting that Blacks are less likely to receive treatment than non-Blacks. I also find that Blacks are statistically significantly less likely to have insurance than non-Blacks (r= -.17). Finally and interestingly, I find that there is no significant relationship between race and reports of experienced mental health symptoms.

Table 2. Bivariate Correlation Matrix

	1	2	3	4	5
(1) Race	1.00	-.017*	-.054*	-.039*	-.001
(2) Insurance		1.00	.065*	.049*	-.023*
(3) Treatment Scale 1			1.00	.864*	.365*
(4) Treatment Scale 2				1.00	.375*
(5) MH Scale					1.00

*$p \leq .05$

Multivariate Regressions

Multivariate regression analysis reveals support for the inverse race and treatment measures even when controlling for insurance and mental health conditions in the past year. As shown in Table 3 below, the adjusted R-squared reveals a coefficient of .141, which means that appro ximately 14 percent of the variation in mental health treatment is explainable by knowing one's race, insurance access and mental health conditions. What is more, when assessing the effects of race, insurance and mental health concerns in the past year, I find that all three of these variables are statistically significantly correlated with self-reported mental health treatment in the past year. In other words, controlling for insurance and mental health condition, African Americans are less likely to receive treatment (b = -.089). Stated more precisely, African Americans are nearly 1 point less likely to receive treatment than non-African Americans even when controlling on insurance and mental health condition.

Table 3. Multivariate Regressions Estimating Effects on Mental Health Treatment

Variables	**Parameter Estimates**
Race	-.089*
	(.008)
Insurance	.123*
	(.008)
Mental Health Condition	.044*
	(.001)

CHAPTER VI

QUALITATIVE RESULTS

For the qualitative portion, I recruited fifteen respondents who identified as having experienced symptoms of anxiety and/or depression. In Appendix F, respondents are listed as interviewed. Below, I discuss 6 themes that emerged from the qualitative, interview data. These themes include identity struggle, stigmatization, distrust of medical providers, image maintenance, religious assumptions/ideologies and dismissal. Each respondent alluded to at least one of these themes; identity struggle being mentioned by eight respondents, stigmatization mentioned by all fifteen, distrust of medical providers by fourteen participants, image maintenance by twelve, religious assumptions/ideologies by eleven and seven participants alluding to some form of dismissal. In fact, the consistent mention of these themes is the reason I identify them as significant. These themes are listed in order of most salient to least. To conclude this chapter, I discuss the implications of these themes and its role in the tendency for African Americans to suffer in silence when experiencing mental health concerns (i.e., living as a lone survivor).

Identity Struggle

As members of a doubly minority status, African American women endure a specific plight unparalleled by many, especially regarding mental wellness. This status

turns to triple upon the admittance of mental health concerns; African American, female and "crazy." Though from varied socioeconomic statuses, education attainment levels and geographic locations, nearly all respondents noted "something" that just won't allow them to seek treatment. Never explicitly identified, yet strong enough to deter each woman from professional treatment that they deemed would be exceedingly beneficial. This "something," I have termed identity struggle. The identifiers of African American and woman, do not allow its members to seek mental health treatment simply because it conflicts with societal expectations of what being an African American woman means.

Conceptualized through scholarly paradigms such as the Superwoman Schema, Sojourner Truth Syndrome, Strong Black Woman Stereotype, as well as in modern media through the Black Girl Magic movement, these expectations have allowed African American women to find fulfilment in the strength they are forced to possess. These expectations, which have been placed onto them by members of society, have been internalized and in many cases viewed as a badge of honor and strength. The women suggest that seeking help goes against of the aforementioned strength and invincibility expectations. The notion of help-seeking, admission of weakness and trust in others (whom are not also African American women) juxtaposing the essence, history and lived experiences of this population. Jasmine well-describes this theme when she states

> As a black woman, you kind of have to keep going. You don't have to, but I feel like we're supposed to. That's how people make it seem, for me at least, if you say you're tired or that you're exhausted, it's like, you're always complaining. It's like, no, I'm not, but I am tired today. (laughs). I

> don't want to be here today, but I am. I feel like for me, it's important for me to keep pushing so other people can do the same thing, so I can be inspiring to other people... (Jasmine)

The data suggest that one precipitant of this identity struggle is the socialization of silence. African American women have been conditioned to compress their voices, actions and feelings so long that the notion of seeking help is not only absurd but feared detrimental. Below, Imani describes her experience of African American womanhood. Though her story cannot be extrapolated to every African American woman, it was echoed in eight interviews conducted for this study.[3]

> So, being a black woman is just inherently difficult, right? You're marginalized in so many ways. First because of your blackness, well, maybe not even first, but your blackness, you're marginalized because of that but also being a woman in such a patriarchal society when womanhood is not valued in the same way as men. So where is the space for us? Outside of each other, in a larger society, where is the space for black women? Where we're valued, where we're heard, where we're able to just be free. That's difficult to find unless it's created by us, distinctly for us. I struggle with that a lot. I have struggles with that at work, school, in business, everywhere you know? You go somewhere and you're treated differently because you're black and you're a woman. Even when you're with black men, folks who identify as black men, (laughs), It's like you can't escape being oppressed in some way. It's like a continuous thing and it's tiring, it's overwhelming, it's exhausting, and just knowing those struggles that I've had, I just want my daughter to have a space where she doesn't, she can be free of that even if it's just, you know, not all day, but a little bit of her time. I think the biggest thing I struggle about with black

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[3] To assist with reading flow, extraneous words such as "um" have been removed. Any quotes used retain the full context and meaning of the participants' answer.

> men is that they always want you to censor your blackness and your woman-ness. Your womanhood is secondary to your blackness, but I can't shed either part of my identity. So, for them, you're always just supposed to be out here, you're supposed to be doing things that benefit the black community and if you're seen as a feminist, you're betraying the race. Black femininity or black women somehow must always uphold and support the black race, but not the womanhood. I think a lot of that goes into men always feeling as if women are supposed to do something for them without recognizing how difficult our plight is. It's easy for a black man to say being black is difficult because they get that, but they don't understand, the difficulty of being a woman and how that's juxtaposed. I don't know if any of that makes sense but they don't understand that I can't just be black. I can't just show up and only be black. I'm going to show up and I'm black and I'm a woman and, because that's very evident because I'm a cis-gendered woman. I can't pick one. I'm both, I show up and I'm both, and a lot of times, they're not cool with that, right? I'm betraying them in some way if I'm censoring my woman-ness. Often, you're supposed to have a man back you up, even if it's not a black man, as if the words that I say don't have the same validity, it doesn't carry the same weight if a man isn't cosigning on what I'm saying. And that's just because the value in what a woman says is not weighted the same as what a man says.

This struggle faced by African American women is an imperative piece of their socialization. The interview data indicate that this strength is also to the detriment of African American women, due to its ability to silence the pain and vulnerability needed to be expressed and in many cases professionally treated. I have conceptualized this crisis to African American women specifically, however there is potential for it (or its equivalent) to encompass men as well. However, the single male I interviewed did not make mention of this conditioned suppression.

Stigmatization

Pertaining to help-seeking behaviors of African American men and women, stigmatization was a leading deterrent from professional and non-professional sources. All participants mentioned having received or expecting to receive judgement from family, friends and other members of the African American community. This stigma prevailed for possessing the mere symptoms of anxiety and/or depression, not just receiving treatment. Having these issues implies a sign of weakness, with differing implications of what said weakness entails. For African American women this weakness includes loss of strength and self-sufficiency, whereas African American men may experience threats to masculinity. Two respondents mentioned that they felt that African American males face more risk upon admittance of mental health concerns, whereas eight respondents implied their image as an African American woman would be altered in some way if they openly disclosed their issues. In speaking about these issues, Kayla states:

> I think that black men may have it harder-because of the way that masculinity is defined, but black women have it hard too because of trying to be these strong, having to be- "I can't necessarily allow this to get to me for too long or too bad or too apparent because then I'm going to be seen as weak." Somebody might take that, and then I'm going to be vulnerable to whatever. So black women may try to cope or find a different way to deal with it or dismiss it all together while black men may want to come forward about it and address it, but it may hit their ego. (Kayla)

This comparison of hardship is worthy of future research to establish empirical viability beyond the sample examined herein; however, the women interviewed for this study discuss stigmatization of mental health disorders as a reason for abstaining from mental health treatment.

As aforementioned, intra-racial discrimination is one of the most influential deterrents from mental health treatment. As an already marginalized group, perhaps this stigmatization serves as a means to differentiate oneself from others in some "better" way. Trell, the only man interviewed for this study, stated

> I feel like if they're like me they would pass it [mental health treatment] up because other black people would look at them as -- it would be weak, like you're black; we've been through all of this. We don't need that, this a white people thing.

When combined with Kayla's statement, this admission of "weakness" could compromise one's masculinity and serves as a deterrent from kinship with fellow African American men; however, as mentioned in the previous theme discussion, such "weakness" also limits Black women from seeking treatment. In other words, the interview participants suggest that race appears to be a primary cause and restraint of mental health symptoms and treatment. Though I question whether race itself can be attributed as a cause of mental illness, it may be an intensifier and precursor to potential mental health concerns. Imani mentions the plight of African Americans as a whole but

also notes the specific plight of its women, thus referencing the identity crisis and revealing the overlaps across these two most-common themes.

> It is so difficult. Even just things we go through now, the systemic racism that this country is built on. Navigating that on a day-to-day basis, it is tiring. I get overwhelmed by just being black today. But I think black folks, we've been handed down this sort of generational mental unwellness. Mentally we had to struggle so long in this country and it's been handed down. I think most of us need some type of help, some type of coping mechanism to, to deal with that.

> Sometimes I don't even know if I'm a human being in this country. I feel like we need and should get counseling for free, just off gate because we need something. But being a black woman is even more difficult because if it's not racism, then it's gender oppression. You're always trying to balance things and you're expected to be strong but you're still seen as weak. We need something. Personally, I know I need something better, that would give me the skills to cope with something when a trigger or a stressor happens, that I can deal with it better in that moment.

Distrust of Medical Providers

Distrust of medical providers spans a myriad of topics, with the most prevalent being lack of cultural congruence and fear of medication (or its excess). Many respondents mentioned their belief that most mental health practitioners were not equipped with the cultural understanding or lived experiences required to assist such a marginalized group. Tiana and Simone mentioned that having an African American clinician could potentially provide some sort of security, in that they could potentially be understood when they described issues they faced.

> In the black community, we always feel more comfortable when the person sitting across from us is black. And I think that's also something that's instilled in us from being little. My doctor is black. My dentist is black. This is black. An d it's like, oh. Well, my counselor's black so I'm going to go talk to them because no one else is going to understand my struggles. But if they're black, they might understand because they're black too. (Tiana)

> They couldn't understand my experiences or little things that I would say are a problem to me. It would feel like they just didn't get it. They were hearing what I was saying but they couldn't really understand it because they had never experienced it. (Simone)

Keisha described her only encounter with a clinician as an experience of victimization. She felt that her white, male clinician focused more on how sorry he was for her, instead of providing methods for coping with what happened.

> I didn't like talking to that person. It was really, I don't know, I felt like he was feeling sorry for me, like too sorry. Everything in his voice and his mannerisms, the way he walked, the way he sat, everything just bothered me because he made me feel like a victim and I didn't want to feel like a victim. I wanted to feel like a normal person who had just went through something.

Though this feeling of victimization was only mentioned once, it did lead to discussion of over-medication, and several participants mentioned their unwillingness to be medicated, expressing concern with being overmedicated (i.e., distrust in medical providers relying too heavily on medication).

> Bernice: I don't believe in giving medicine. A lot of times people just need somebody to talk to. No "you need to take this so you won't be depressed" or you know, just someone to talk to. You just need help to cope with it.
>
> Interviewer: So would you not want to take medicine?
>
> Bernice: I wouldn't want to take medicine because I'm thinking there's nothing wrong with me, by being depressed or whatever. Why would I need a medicine for depression when it's just maybe things that have happened to me in my past or adulthood. And me not actually knowing how to handle it. What is a pill going to do for my thinking? To me, pills are meant for pain or stuff like that.
>
> I just feel like as a society we kind of over medicate, and I don't like that. And I've learned a lot about that with wanting to be a pediatric dentist that we over medicate sometimes and over antibiotic and all this stuff and it's causing a lot of problems in our society. So, I don't want to be a part of that problem if I can help it. (Jasmine)

In these cases, discussion arose about the purpose of medication and the definition of pain. In Brenda's example, she stated that medicine is used for pain, yet she felt strongly against medication for emotional troubles, including mental health challenges. With this rationale, I was left wondering does psychological suffering not equate to pain? Could Bernice's argument allude to the fact that some form of suffering is to be expected for African Americans, and specifically among its women?

Image Maintenance

As earlier stated, it is rare that African American women share sensitive information with individuals who are not also African American women. Expressions of vulnerability appear to hold less chance of scrutinization when disclosed to African American women, whom they presumed faced similar struggles. Below are excerpts from Simone and Sheba, detailing the importance of fellow African American women that can serve as a buffer and source of ventilation from everyday issues. It should be noted that though not stated in this quote, Simone alluded to her closest relationships being with other African American women, thereby leading me to assume the individuals she tells are also of this category.

> I think it [treatment] probably would be beneficial but I think that just in general, I don't trust people and for me to let people in like that, is being super vulnerable and I don't like letting people have that type of control over me because I can control all that stuff for myself. I just feel you never know how people are going to take that information and use it. And so, I choose to share it with very, very few people that I do know wouldn't do anything with it. (Simone)

> What I have found and what I have noticed, particularly over the past year, is I find a lot of support in other black women. Even if we come from very different backgrounds, if we're in different career fields, just having conversations with other black women, I find that we go through a lot of the same things, as far as with dealing with other people in society and not being able to go to anyone else to get help. We've found that, "Okay, well since we can't go anywhere else, we just going to help each other." So, being around other black women, I find strength in that and I feel secure in talking to them about things that I go through because I know a lot of them have and are going through the same types of things.

> Honestly, from this point, I will just rely on that. I don't think I would ever really seek professional treatment, unless it was somebody that I knew that happened to be a professional. I'll just depend on my fellow black women and they can depend on me. (Sheba)

I interpret the participant's reliance and explicit discussions of trusting other African American women as their strategically choosing what information is known about them. By making sure that they remain selectively secretive about any mental health struggles, the personal and collective image of "strong", "unbothered" and "successful" remain intact.

Religious Assumptions/Ideologies

Due to the historical importance of the Black Church, it should be no surprise that religious ideologies were mentioned by eleven participants. Of these, seven respondents viewed religion as a coping mechanism for life in general, though not solely in relation to mental health conditions specifically. The remaining four participants did not view religion as a viable means to cope with stresses of life or mental health concerns.

Notably, of the eleven participants who mentioned religion, six explicitly stated they were advocates of incorporating mental health treatment in addition to religion and acknowledging them both in their own rights. Three individuals expressed preference for faith-based clinicians, if they were to seek treatment. Though literature on African American mental illness suggests religion serves as a hinderance in receiving mental health treatment, much of the commentary received during the interview process implies

otherwise. In the comments below, Tiana and Jasmine articulate the importance of mental health practitioners and its acceptance among many of those who identify as religious.

Despite this acceptance, participants continue to avoid treatment, illustrating religion is not the only restraint in obtaining needed mental health treatment.

> Now, would God let somebody go to school for this long, or let doctors be in school for this long, if we weren't supposed to go to the doctor? Or if we weren't supposed to go to counseling? Or if we weren't supposed to take medicine? No. No He wouldn't. You're supposed to get healing, and God provides healing in whatever avenue is supposed to get you there. (Tiana)

> ...it's not a bad thing that the African American community leans on faith. I feel like that's important and it's a good foundation to have but sometimes we lean on it too much...these pastors are telling people that they don't need to be taking their medication. And yes, they can be delivered from whatever it is you're saying sometimes, but don't tell these people not to take their medication. It was diagnosed for a reason and sometimes maybe they shouldn't be on it, but you have to understand that that's a different field than what you're in and though your faith is important, so is mental health.... my pastor's not a psychiatrist, just saying. (Jasmine)

It was not uncommon for respondents to discuss their issues with those closest to them, such as family or friends. Each participant had disclosed to at least one individual, fourteen of which indicated telling an elder (note: Trell, the male respondent, did not). It is unclear why respondents chose these individuals; however, I would assume this was done for guidance and wisdom that participants felt they needed when navigating their

anxious and/or depressive symptoms. When respondents mentioned telling older members of their social network, such as their mothers, fathers and grandmothers, many described scenarios such as these:

> I tried to talk to her [respondent's mother] about it and she was like, "Pray about it. We're not claiming that." ... And it might be the traditional church. Maybe not the 'new" church. It might be the traditional values of the black church where they don't think that's necessarily a thing that you should get help for or something that you can pray away or whatever. (Rochelle)

> I know she's [respondent's mother] trying to help but it's always pray about it. Pray about it, you know, we're not going to claim that. Pray about it, you know. She'll send me scripture and everything and, it's very encouraging but, I think sometimes I feel like I need to talk through some things with somebody who knows how to deal with those types of symptoms. (Sia)

These excerpts indicate a potential link of age and dependence on religion for mental health concerns. While this study did not look at this, it will be briefly mentioned in the concluding chapter.

Dismissal

It is important to note that most respondents recognize their mental health symptoms. The severity of these symptoms and their worthiness of mental health treatment tend to be dismissed. In fact, many participants readily identify their mental health concerns and their need for new coping mechanisms for these issues. In any case,

professional mental health treatment continues to be ruled out as a viable option. Below is an excerpt from Jackie's interview where she notes that mental health treatment is only for those who harm themselves. This perspective suggests that psychological self-harm, such as repetitive negative thoughts about one's self, constant feelings of worthlessness and/or helplessness are not, in fact, harmful.

> Jackie: I didn't think my situation was that serious that I needed it [treatment], because I never tried to harm myself or nobody else.
>
> Interviewer: You think that mental health treatment is only for those who try to harm themselves or others?
>
> Jackie: Yeah.

Lone Survivorship: Explaining Links between Racialization and Rejection of Mental Health Treatment

When considering the aforementioned thematic responses, it is imperative to note potential social, emotional and psychological implications. These implications may be manifested in numerous ways; however, I deem lone survivorship as an encapsulating term of which to define the tendency for African Americans to reject disclosure and exhibit low professional help-seeking behaviors. The ingredients of identity struggle, stigmatization, distrust of medical providers, image maintenance, religious assumptions/ideologies, and dismissal, in full combination or certain mixtures, serve as a deterring factor from seeking and maintaining professional mental health treatment.

Though not the primary focus of this study, these themes may also influence non-professional help-seeking behaviors as well. Friends, family and other members of one's social network often remain unaware of their loved one's experiences with anxiety and/or depression. This unapparent phenomenon may be purposeful or coincidental; however, I expect that it is disproportionately evident within the African American community.

For clarification purposes, the Lone Survivor is the African American individual who is unable or unwilling to seek adequate mental health treatment due to adversity, stigmatization and mental health conditions. Due to these factors, it is often the case that individuals suffer these illnesses alone, finding this to be a more beneficial alternative to treatment services. This conceptualization not only describes the unfortunate predicament of those whom experience its symptoms, but also illustrates the strength and endurance needed to survive.

CHAPTER VII

CONCLUSION

To examine African American mental health help-seeking behaviors, this project employs quantitative analysis of a nationally representative sample of Black and non-Black US residents. In addition, I conducted fifteen qualitative interviews with African Americans who report experiencing anxious and/or depressive symptoms but refused treatment. Using Agnew's General Strain Theory and Link et al's Labeling Theory, I discussed the potential influence of cumulative strain and stigmatization in the matter of obtaining mental health treatment. By incorporating current mental health literature, I consider the sociological ramifications of mental illness, racial determinants, stigmatization, the racialization of stigmatization and the intersectionality of stigmatization. This data suggest a life experience that I coin "the lone survivor", which reflects the ways in which African Americans are deterred from mental health treatment.

Ideally, no variation of mental health treatment should exist. Individuals who feel that formalized, professional mental health treatment would be beneficial, would find it accessible and free of repercussions. Those who find non-professional methods of treatment more advantageous, would do so for reasons other than adversity or stigmatization. However, there is a deficit in African American mental health literature

that includes the personal experiences of individuals living through a myriad of symptoms and realistic methods of receiving assistance with dealing with said concerns.

This study serves as a microscopic lens into the lives of those surviving insurmountable circumstances, unbeknownst to much of society.

Limitations

As with all social science research, this study is not without its flaws. A lack of data variation in relation to sex, gender and that may affect the generalizability of these findings. For instance, of the fifteen participants interviewed, only one respondent was male. Given the high representation of women in my qualitative sample, critics may argue that thematic gender differences may arise; however, much of the current literature on African American male mental health supports my findings. For example, studies find that both African American men and women report an importance for self-preservation (Corrigan et al 2014; Forsyth and Carter, 2012). For African American males, this is to protect hegemonic norms of masculinity; whereas for African American females, this is to maintain the notion of strength and self-sufficiency. In my findings, this may be compared to themes of identity struggle, stigmatization and image maintenance. This disproportionate number of male respondents may also speak to the notion of black masculinity and its role in discouraging help-seeking behavior among African American men.

Despite the breadth of the topics discussed, there were others that were mentioned too few times to be explored as a theme. These included age effects in regard to religious dependency, mental health concerns and its relations to childhood bullying, and physiological effects from symptoms of anxiety and/or depression. Participants mentioned that when they disclosed to elders of their social networks (parents, grandparents), the elders usually mentioned religion being the sole alleviation of anxious and/or depressive symptoms. A few participants also related their experiences of bullying during primary education to the onset and/or exacerbation of their mental health symptoms. Their experience somehow convinced them that they deserved the punishment they were given, making them feel unworthy of being happy and free of their mental health symptoms. Given the historical socialization practices of disdain taught to African Americans, one could expect feelings of deservedness to be experienced by this population when victimized. Along with this, two individuals stated they experience physiological symptoms such as general heaviness, fatigue and irritability upon the arrival of anxious and/or depressive symptoms.

For continued research, confronting these limitations would benefit the discipline on a micro and macro-level. By including those of varied class, gender, sexual orientation, geographic locations and the like, there is much more to be learned about the intricacies of suffering in plain sight.

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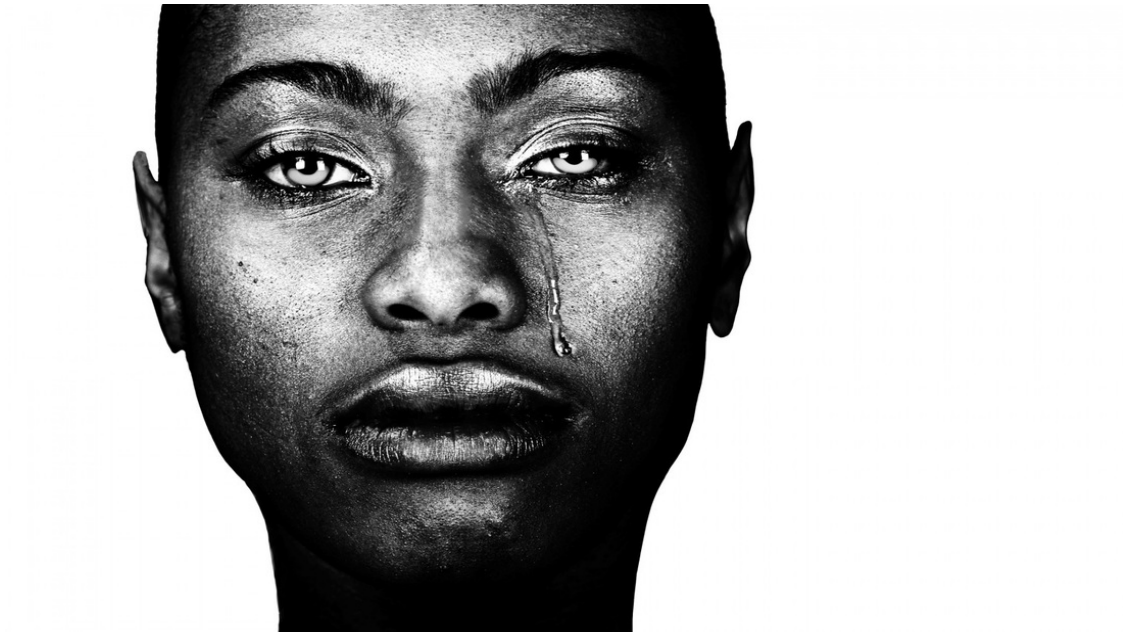
APPENDIX A

FLYER

More than just the blues?



I want to know about your experience!

Purpose of Study:

I aim to understand reasons why African American men and women decide not to seek mental health treatment.

I am seeking participants who:

- Identify as African American or Black.
- Experience or have experienced symptoms of anxiety and/or depression.
- Have not received mental health treatment for these symptoms (even if you have contemplated it).

Participants will participate in one-on-one in-depth interview about topics relating to the participant's reasons for or against receiving mental health treatment. All participants will receive a $25 Visa gift card upon completion of the interview.

If you are interested in participating in this study, please contact Mary John, the UNCG Department of Sociology, at *mejohn@uncg.edu.*

UNCG

APPENDIX B

CONSENT FORM

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

CONSENT TO ACT AS A HUMAN PARTICIPANT

Project Title: Lone Survivor: Linking Institutionalized Racial Adversity, Lived Experiences and Mental Health Conditions among African Americans

Principal Investigator and Faculty Advisor (if applicable): Mary John (PI); Dr. Cindy Brooks Dollar (FA)

Participant's Name: _____

What are some general things you should know about research studies?

You are being asked to take part in a research study. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. There may not be any direct benefit to you for being in the research study. There also may be risks to being in research studies. If you choose not to

be in the study or leave the study before it is done, it will not affect your relationship with the researcher or the University of North Carolina at Greensboro.

Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study.

You will be given a copy of this consent form. If you have any questions about this study at any time, you should ask the researchers named in this consent form. Their contact information is below.

What is the study about?

This is a research project. Your participation is voluntary. This study will explore reasons why African American men and women decide not to receive mental health treatment.

Why are you asking me?

You were selected to participate because you have self-identified as African American that has or currently experience symptoms of anxiety and/or depression, and have not obtained professional mental health treatment.

What will you ask me to do if I agree to be in the study?

You will be asked to participate in a 1-2 hour in person interview, including a pre-screen demographic survey, with the principal researcher, Mary John. The interview will occur in a mutually agreed upon, quiet location.

As part of this interview, you will be asked about various aspects of your personal history and current life experiences (including your self-described routines, relationship and work status, and general well-being) and your mental health symptoms. If you have any questions or concerns during the interview, you may stop at any time until your questions or concerns are fully addressed.

Is there any audio/video recording?

Interviews for each participant will be recorded using a digital audio recording device. The recording will not be published in any way. The file will be held on a password protected external hard drive kept in the principal investigator's locked file cabinet.

However, because your voice will be potentially identifiable by anyone who hears the recording, your confidentiality for things you say on the recording cannot be guaranteed although the researcher will try to limit access to the recording as described below.

Written transcripts will be available to the research team and the IRB. The research team will consist of the principal researcher, Mary John, and the Thesis Committee, Dr. Cindy Brooks Dollar, Dr. Shelly Brown-Jeffy and Dr. Steve Kroll-Smith.

How will you keep my information confidential?

Pseudonyms will be used on all documentation to ensure participants' confidentiality. Participants will NOT be identified in any reports or publications resulting from this study. The interview recordings will be stored on an external hard drive and kept in a locked file cabinet that only the faculty researcher has access to. All information obtained in this study is strictly confidential unless disclosure is required by law.

After completion of the study, transcripts and recordings will be kept in a locked file cabinet indefinitely.

What are the risks to me?

The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. The primary risk is the discussion of this information may cause some stress.

If you have any emotional concerns, please contact your personal physician or the Counseling Center at the University of North Carolina at Greensboro's Student Health Center.

If you have questions, want more information or have suggestions, please contact Mary John or Dr. Cindy Brooks Dollar who may be reached at (334) 334-5409. You may also reach Mary John at mejohn@uncg.edu.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study, please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

Are there any benefits to society as a result of me taking part in this research?

This study may provide insights about factors deterring African Americans from need mental health treatment and potential implications this may have.

Are there any benefits for *me* taking part in this research study?

Participants will receive a $25 Visa gift card upon completion of the interview.

What if I want to leave the study?

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed. The investigators also have the right to stop your participation at any time.

What about new information/changes in the study?

If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

Voluntary Consent by Participant:

By signing this consent form you are agreeing that you read and fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By signing this form, you are agreeing that you are 18 years of age or older and are agreeing to participate in this study described to you by principal investigator, Mary John.

Signature:_____ Date:_____

APPENDIX C

INTERVIEW GUIDE

The following questions will serve as an interview guide, though respondents' answers may lead to unforeseen questions.

Before I begin, I want you to know that this interview is completely voluntary. If we should come to any questions you don't want to answer, just let me know and we can skip it and move on to another question. The answers that you give will be kept confidential. I am going to ask you to read this document (provide Adult Consent form). Please read this; let me know when you are finished. If there are any questions or concerns please let me know.

1. Let's start with you me a little about yourself. How old are you? Where were you raised? Where do you currently live? What is your education experience? Those kinds of things.
2. Tell me about yourself.
3. How do you think people see you? Does this conflict with how you see yourself?

Family

4. What is your family like?

5. Are there any family members you feel you could bring your issues to? Are there any issues that are off-limits?

Strain/Coping mechanisms

6. How do you cope with day to day life?
7. Is this any different than how you cope for particularly difficult situations? How so?
8. In the past year, with whom have you discussed personal worries? This can be worries about education, family, yourself, etc.? Anyone else?

Mental health condition(s)

9. Describe your symptoms and why they lead you to believe you experience symptoms of anxiety and/or depression?
10. How long have you been experiencing this?
11. Do you feel that you have particular stressors or is this something that remains constant?
12. Is there ever a time where these feelings aren't present?
13. Have you told anyone else about these experiences?
14. Why/why not?

Labeling/Stigma

15. What are your feelings about mental health counseling?
16. Do you think people in counseling or treatment are treated any differently than everyone else? How so?
17. Does their gender have an effect in that?
18. What about their race? For African Americans specifically?
19. Do you think those in counseling can avoid these stigmas?
20. If you were to get mental health counseling, do you think this would still apply? (assuming they said some things for the above questions)

Coping Strategies/Peer and community relations

21. In the past year, who has spent time with you in social activities such as having dinner together, going to the movies, hanging out, or talking on the telephone? Anyone else?
22. In the past year, whose advice have you considered in making important decisions? Anyone else?
23. Is there anything else you would like to add that I may have missed?

APPENDIX D

RESOURCE LIST

Upon completion of our interview, if you feel the need to reach out to a mental health professional, here are some resources. This list is not exhaustive and should only be used as a guide to find a potential care provider.

For UNCG students:

UNCG Gove Student Health Center

107 Gray Drive

Greensboro, NC 27412

(336) 334-5340

For members of Guilford County:

Behavioral Health Services

The Bellemeade Center

201 N. Eugene St.

Greensboro, NC 27401

(336) 676-6840

Hours of operation: Monday-Friday, 8:30-5 p.m.

Mental Health Association in Greensboro

01 E. Washington St., Suite 111

Greensboro, NC 27401

(336) 373-1402

National Suicide Prevention Lifeline

1 (800) 273-8255

APPENDIX E

SAMPLE DESCRIPTION

Table 4. Sample Description

Participant	Age	Education	Experience
Simone	29	Master's degree	Anxiety Depression
Kayla	21	Bachelor's degree Graduating with Master's degree (May)	Anxiety Depression
Sheba	25	Bachelor's degree Graduating with Master's degree (May)	Anxiety Depression
Jackie	45	High school diploma Enrolled in bachelor's program	Anxiety Depression
Bernice	44	Master's degree	Depression
Helen	47	High school diploma	Depression
Jasmine	21	Enrolled in bachelor's program	Anxiety Depression
Sia	19	Enrolled in bachelor's program	Anxiety Depression
Courtney (via video)	22	Bachelor's degree	Anxiety Depression
Tiana	+/- 21	Enrolled in bachelor's program	Anxiety Depression
Monique	40	Master's degree	Anxiety Depression
Keisha	+/- 21	Enrolled in bachelor's program	Anxiety Depression

Participant	Age	Education	Experience
Rochelle	33	Bachelor's degree	Anxiety Depression
Imani	34	Bachelor's degree	Anxiety Bouts of depression
Trell (M) (via video)	23	Bachelor's degree	Depression