NTS OF HEALT
WOMEN BY S

May 12, 2023

Issues: Discrimination in Health Care, Expanding Health Coverage, General Health Care & Coverage, Health Benefits, Health Care & Reproductive Rights, In the States, Racial Justice, Reforming Insurance Practices

Download Files

Black women experience great barriers to good health and quality health care. In nearly every state, Black women face higher levels of no health insurance coverage, poverty, food insufficiency, and housing insecurity compared to white, non-Hispanic men and women. These inequities operate as barriers to living healthy lives. A lack of health insurance coverage makes it more difficult for Black women to access and afford health care. Those living in poverty have higher rates of chronic diseases and overall worse physical and mental health. Those experiencing food insufficiency and housing insecurity also face worse health, including greater chronic health and mental health conditionsii. Deep inequities in our economic and health systems have led to Black women having access to fewer resources and overall poorer health.

Nationally, nearly one in eight Black women (12.0%) ages 19 to 64 lacked health insurance coverage between 2017 and 2021. In comparison, 10.2% of white, non-Hispanic men and 7.6% of white, non-Hispanic women did not have health insurance nationally. The share of Black women without health insurance varies greatly by state. For example,

6.3% of Black women in California lack health insurance while 19.5% of Black women in Texas lack health insurance.

More than one in six Black women (18.8%) ages 18 and over nationally lived in poverty in 2021 compared to 7.1% of white, non-Hispanic men and 8.9% of white, non-Hispanic women. However, Black women in many states fared worse. In Idaho, 38.4% of Black women live in poverty, over twice the national poverty rate for Black women. Meanwhile, 8.7% of white, non-Hispanic men and 10.8% of white, non-Hispanic women lived in poverty in 2021 in Idaho. Overall, Black women in many states report worse health than white, non-Hispanic men and women. The following table provides data by state on social determinants of health metrics for Black women.

Social Determinants of Health Metrics for Black Wor

State	Health Uninsurance (Aged 19-64) (2017-2021)	Fair/Poor Health (Age 18+) (2021)	Poverty (Age 18+ (2021)
United States	*12.0%*	*21.6%*	*18.8%*
Alabama	14.0%	26.6%	24.6%
Alaska	-	-	15.6%
Arizona	11.7%	22.6%	15.8%
Arkansas	10.3%	28.0%	26.8%
California	6.3%	20.7%	18.7%
Colorado	9.5%	21.1%	19.5%
Connecticut	6.8%	20.3%	14.4%
Delaware	5.9%	19.3%	17.6%
District of Columbia	3.5%	21.5%	28.1%
Florida	18.5%	18.4%*	19.9%
Georgia	17.0%	19.0%	18.9%
Hawaii	-	-	10.7%
Idaho	-	-	38.4%
Illinois	9.9%	22.3%	22.6%
Indiana	11.4%	24.1%	20.1%
Iowa	11.9%	19.1%	27.8%
Kansas	17.6%	26.9%	22.8%
Kentucky	7.4%	24.7%	22.3%
Louisiana	9.2%	26.9%	30.3%
Maine	-	-	25.9%
Maryland	6.2%	16.4%	14.0%
Massachusetts	4.6%	17.0%	16.9%
Michigan	7.0%	26.9%	24.1%
Minnesota	8.5%	18.1%	20.3%

SEE THE FULL BREAKDOWN STATE BY STATE

PRESS ROOM
CONTACT
LEGAL HELP
JOBS

Phone: (202) 588 5180

Health (https://www.hopkinsmedicine.org/health)

Mental Health Among African American Women

Women's Health: Mind and Mood (https://www.hopkinsmedicine.org/health/wellness-and-prevention/womens-health-mind-and-mood)

Featured Expert

Erica Martin Richards, M.D., Ph.D.
(https://www.hopkinsmedicine.orghttps://profiles.hopkinsmedicine.org/provider/Erica+Richards/2702349)

It’s true that everyone experiences temporary periods of sadness, and times of worry and nervousness. But what about when those feelings won’t go away? Too often, women of color try to muscle their way through depression and anxiety on their own says Erica Richards (https://www.hopkinsmedicine.orghttps://www.hopkinsmedicine.org/profiles/results/directory/profile/10003974/erica-richards), chair and medical director of the Department of Psychiatry and

Behavioral Health at Sibley Memorial Hospital. This can be a mistake: What you really need is someone to help you sort out what you're going through and to provide support and treatment options.

"Anyone can experience mental illness. There is no group, gender, sexual identity, race or cultural belief that can prevent it from occurring," says Richards. "And it's actually happening at higher rates than most other illnesses, including heart disease, diabetes and cancer."

That's especially alarming for minority women. Women are at least twice as likely to experience an episode of major depression as men, Richards reports. And, compared to their Caucasian women, African American women are only half as likely to seek help.

Access to mental health care with cultural sensitivity is often listed as a consideration for minority women seeking care from psychiatric providers. More people, including high-profile celebrities — actors, singers and political representatives from minority communities — are opening up about their battles with depression, including, at times, thoughts of suicide. Recently, several high-profile suicides have initiated conversations about treatment options and the devastating impact of suicide on family and friends left to process their loss. Normalizing this discussion will continue to be a key factor in helping others identify when and how to seek help.

Make Mental Health Your Priority

Part of the challenge in getting care is the cultural belief that only people who are “crazy” or “weak” see mental health professionals. “There’s a feeling in a lot of Black communities that women have to be strong and stoic,” Richards explains. “Women are so busy taking care of everyone else — their partners, their elderly parents and their children — they don’t take care of themselves. However, women should be reminded that attending to their own needs, whether physical or emotional, doesn’t make you weak. It makes you better able to care for your loved ones in the long run.”

There’s no replacement for the help you can get from a mental health professional. But, you can also safeguard your emotional health through these self-care practices:

Get good rest: Aim for at least seven hours of sleep each night. Lack of sleep destabilizes your mood, making everything you do less effective.

Move more: Exercise 30 minutes every day for better health and a boost of feel-good endorphins that can help some people manage or prevent depression symptoms.

Eat well: A healthy mix of fruits, vegetables and protein keeps energy levels steady, helping you better manage the ups and downs of your day.

Connect: Schedule time with a friend every week, even for a quick cup of coffee or a walk. Many studies have shown that social support improves women’s mental well-being, helping to reduce stress and the effects of depression.

Meditate: Johns Hopkins researchers found that people who took an eight-week course in mindfulness meditation

(https://www.hopkinsmedicine.orghttp://www.hopkinsmedicine.org/health/healthy-woman/mind-mood/need-stress-relief-try-mindfulness-meditation)were able to improve their depression, anxiety and pain symptoms.

Know your limits: As much as possible, decline requests that create unnecessary stress, such as hosting parties or planning events. Setting boundaries at work, such as not checking email after a certain time, can also help reduce stress.

Signs of Depression and Mood Disorders

What's the difference between feeling blue or run-down and something more serious? Depression is most common between the ages of 25 and 44, but can occur at any age, says Richards. And while depression (https://www.hopkinsmedicine.orghttps://www.hopkinsmedicine.org/healthlibrary/conditions/mens_health/depression_85,p01512) is the most common mood disorder, anxiety disorders (https://www.hopkinsmedicine.orghttps://www.hopkinsmedicine.org/healthlibrary/conditions/adult/mental_health_disorders/anxiety_disorders_85,P00741) and bipolar disorder (https://www.hopkinsmedicine.orghttps://www.hopkinsmedicine.org/healthlibrary/conditions/adult/mental_health_disorders/bipolar_disorder_85,P00743) are prevalent, too. Some signs that indicate a mental health condition include:

Sleeping more or less than usual

Increased or decreased appetite

Feeling worthless, hopeless or empty

Feeling disinterested and unable to enjoy things that usually bring pleasure

Mood swings

Feeling out of control

Difficulty concentrating

If you or a loved one have experienced these or other symptoms for two weeks or longer, you should seek help from a health professional.

Treatment Options and Finding the Right Support

As a woman of color, you may want to find a health care provider who looks like you or who has had similar life experiences. It's understandable, but difficult to do. Unfortunately, women of color make up less than 5% of psychiatrists, psychologists and social workers available to treat patients.

Instead, says Richards, focus on connecting with a provider who is open to learning about you and your life circumstances. It doesn't have to be someone who specializes in mental health and may not necessarily be a provider of color. Often, primary care doctors and gynecologists feel comfortable prescribing medications to treat depression, anxiety and other mood disorders, and they can often refer you to a colleague who can provide additional specialized treatment (medications and/or talk therapy). What's important is

that your team of providers get to know you, work with you to make a diagnosis and establish a treatment plan that is right for you. Learn more about factors to consider when choosing a therapist.

Taking the First Steps

Talk to your primary care doctor or gynecologist.

Reach out to a friend, partner or community member you trust.

Remain consistent and committed to your treatment.

Remember, there are millions of people with depression who are getting treatment and living successful lives. Join them and take control of your health.

#TomorrowsDiscoveries: How the Brain Processes Incentives and Rewards | Vikram S. Chib, Ph.D.

Johns Hopkins researcher Vikram S. Chib studies the way incentives and rewards work in the brain and how this can lead to breakthroughs in depression treatment.

Request an Appointment

Maryland **410-955-5000**

Outside of Maryland **855-695-4872**

International **+1-410-502-7683**

Related

Low Sex Drive — Could It Be a Sign of Depression? (https://www.hopkinsmedicine.org/health/wellness-and-prevention/low-sex-drive-could-it-be-a-sign-of-depression)

Baby Blues and Postpartum Depression: Mood Disorders and Pregnancy (https://www.hopkinsmedicine.org/health/wellness-and-prevention/postpartum-mood-disorders-what-new-moms-need-to-know)

The Benefits of Having a Healthy Relationship with Chocolate (https://www.hopkinsmedicine.org/health/wellness-and-prevention/the-benefits-of-having-a-healthy-relationship-with-chocolate)

Related Topics

Women's Health: Mind and Mood (https://www.hopkinsmedicine.org/health/wellness-and-prevention/womens-health-mind-and-mood)

Published in final edited form as:

J Best Pract Health Prof Divers. 2016 ; 9(1): 1124–1144.

Superwoman Schema, Stigma, Spirituality, and Culturally Sensitive Providers: Factors Influencing African American Women's Use of Mental Health Services

Cheryl Woods-Giscombe, PhD, RN, PmhnP-BC[1], **Millicent Nicolle Robinson, BA**[2], **Dana Carthon, PhD, MSN, RN**[3], **Stephanie Devane-Johnson, PhD, CNM**[1], **Giselle Corbie-Smith, MD, MSC**[4]

[1]School of Nursing, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina;

[2]School of Social Work, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina;

[3]School of Nursing, Michigan State University, East Lansing, Michigan

[4]School of Medicine, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina;

Abstract

Many African American women are heavily burdened by unmet mental health needs yet underuse mental health services. The superwoman schema (SWS) conceptual framework provides a new culturally sensitive framework to enhance researchers', providers', and educators' understanding of the barriers to mental health service use among this group. The "superwoman" role involves perceived obligations to (1) project strength, (2) suppress emotions, (3) resist feelings of vulnerability and dependence, (4) succeed despite limited resources, and (5) prioritize caregiving over self-care. In this study, the SWS framework guided a secondary qualitative analysis of data from eight focus groups comprised of 48 African American women from the southeastern United States and a broad range of age and educational backgrounds. Results suggest that the major components of SWS, as well as perceived stigma, religious and spiritual concerns, and the desire for culturally sensitive providers influenced participants' perceptions and use of mental healthcare. Understanding how SWS operates in African American women may (1) enable researchers to better understand and develop interventions to mitigate disparities in mental health service use; (2) help healthcare professionals to engage and treat this population more effectively; and (3) equip health professions educators to improve the cultural sensitivity of the next generation of providers.

Keywords

African American Women; Disparities; Mental Health Care Use; Superwoman Schema

Corresponding Author: Cheryl Woods-Giscombe, School of Nursing, 4015 Carrington Hall, CB#7460, University of North Carolina at Chapel Hill, Chapel Hill, NC 27599 (Cheryl.Giscombe@unc.edu).

Authors' Note: Dr. Cheryl Woods-Giscombe, PhD, PMHNP, received support from the Josiah Macy Foundation, Macy Faculty Scholars Program, and National Institute of Nursing Research and National Institute of Minority Health and Health Disparities grant number P20 NR8360 to conduct this research. Ms. Millicent Robinson received support from the UNC Chapel Hill McNair Scholars Program, and Dr. Dana Carthron received support from the UNC Chapel Hill Center for Health Equity Research. Dr. Stephanie Devane-Johnson received support from the W.K. Kellogg Foundation. Dr. Giselle Corbie-Smith received support from National Institutes of Health/National Heart, Lung, and Blood Institute grant numbers 5K24HL105493-07 and R01 HL120690-03.

INTRODUCTION

Depression and severe psychological distress are urgent health challenges in the 21st century. Each year, nearly 7 percent of US adults have major depressive disorder (National Institute of Mental Health [NIMH], 2016), and depression is one of the leading causes of disability among US adults (US Burden of Disease Collaborators, 2013). At the same time, findings from the literature on ethnic differences in depression and mental illness are often mixed and difficult to interpret. According to some estimates, African Americans are less likely than non-Hispanic whites to experience major depressive disorder in any given year (NIMH, 2016). However, according to data from the 2005–2006 National Health and Nutrition Examination Survey (NHANES), 8 percent of African Americans suffered from depression compared to slightly less than 5 percent of non-Hispanic white Americans (Pratt & Brody, 2008). Similarly, national data reported by the Centers for Disease Control and Prevention (CDC, 2012) show that African Americans are more likely to report major depression and to experience psychological distress than non-Hispanic white Americans. Data from the National Survey of American Life revealed that African Americans experience more chronic morbidity related to depressive symptoms than white Americans (Williams et al., 2007).

The US Surgeon General's groundbreaking 2001 report, *Mental Health: Culture, Race, and Ethnicity*, revealed disparities in mental healthcare services between African Americans and non-Hispanic white Americans. It clearly explicated that racial and ethnic minorities bear a heavier burden of unmet mental health needs than their non-Hispanic white counterparts. Specifically, "Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality" (US Department of Health and Human Services [DHHS], 2001, p. 3).

More recent studies have documented the underuse of mental health services among African Americans, women in particular. According to data reported by the CDC (2012), in 2011, approximately 7.5 percent of African Americans sought treatment for depression compared to approximately 13.6 percent of the general population. In addition, African Americans are less likely to return for follow-up care with mental health providers after the initial visit. Among those who do engage in therapy, the course of treatment is shorter. African Americans are less likely to be prescribed antidepressants to treat symptoms of depression and more likely to terminate psychotherapy prematurely (Brown & Palenchar, 2004; Miranda & Cooper, 2004).

The data also showed that African American women are more likely than white American women to report feelings of sadness, hopelessness, worthlessness, or that everything is an effort all of the time (CDC, 2012). Lower income levels and educational attainment and exposure to such life-event stressors as trauma, violence, and racial discrimination place African American women at particularly high risk for depression and psychological distress. However, according to Moore and Madison-Colmore (2005), despite these stressors, many African American women do not seek professional counseling. In one study, 41 percent of African American women reported seeking care for depression in the previous 12 months compared with 60 percent of non-Hispanic white women (Alegria, Chatterji, Wells, et al.,

2008). A national study conducted by the California Black Women's Health Project (2003) revealed that 60 percent of African American women experience symptoms of depression, but another report revealed that only 12 percent seek help and/or treatment (National Alliance on Mental Illness, 2009).

Previous research has attempted to identify factors that explain disparities in mental healthcare use among African American women. According to Copeland and Snyder (2010), barriers to mental health treatment services among low-income African American women go beyond lack of financial resources to include mistrust of healthcare providers, cultural differences, stigma, and, sometimes, lack of awareness of available services. African American women encounter psychological distress due to their historically determined structural, cultural, and familial positions in US society (Woods-Giscombe, 2008; Woods-Giscombe, Lobel, Zimmer, Cene, & Corbie-Smith, 2015). Their experience of gendered racism, stereotyping, oppression, as well as economic strain increase their risk for impaired mental health (Stevens-Watkins, Perry, Pullen, Jewell, & Oscar, 2014). They also face tremendous social, economic, cultural, and institutional barriers to the healthcare services required to achieve optimal psychological wellbeing for themselves and their children (Copeland & Snyder, 2010).

Mistrust of providers has been identified among factors influencing African American women's underuse of mental health services. According to Holden and colleagues (2013), African Americans may be underdiagnosed and undertreated for affective disorders and overdiagnosed and overtreated for psychotic disorders. They are also less likely than whites to receive newer and more comprehensive treatment modalities, a disparity attributed to bias and a lack of cultural competency in mental health and medical professionals' service delivery (Holden, Bradford, Hall, & Belton, 2013). Lack of trust in providers was the most commonly reported barrier in a study of perceptions of mental health services among low-income, perinatal African American women, who endorsed it more frequently than white women (Leis, Mendelson, Perry, & Tandon, 2011). Concerns about providers' judgmental attitudes and dissatisfaction with care, specifically discontinuity and wait for services, were identified as barriers (Copeland & Snyder, 2010). The most common reason for not wanting to talk to a mental healthcare provider was a woman's perception that the provider would immediately want to put her on medication (Leis et al., 2011). Women reported that the provider might not be able to relate to them or vice versa and preferred to talk to a family member to whom they could relate more easily. Remarkably, in a study of mental health service use by African American women, researchers found that although lesbians viewed the gender and sexual orientation of the provider as more salient than did heterosexual women, both groups agreed that his or her race was important (Matthews & Hughes, 2001).

Stigma has also been identified as an important influence on use of mental healthcare services among African American women. Mental illness in the African American community has been associated with shame and embarrassment (Thompson-Sanders et al., 2004), and both the affected individual and the family may hide the illness to preserve their reputation (Ward, Mengesha, & Heidrich, 2009). Mental health stigma is related to a concept termed *self-concealment* (Masuda, Anderson, & Edmonds, 2012). As opposed to *enact stigma*, which is directed toward others, self-concealment directs negative attitudes

toward the self, as internalized stigma. Mental health stigma and self-concealment have been positively correlated, and both are negatively associated with help-seeking attitudes (Masuda et al., 2012).

According to Ward, Mengesha, and Issa, older African American women did not seek mental healthcare for depression because they believed it was a normal reaction to difficult life situations rather than an illness that needed immediate attention. Instead of using mental healthcare services, they used “culturally sanctioned” behaviors, including religious practices and resilience (2014, p. 54).

Previous research demonstrates that culturally competent care for African Americans involves sensitivity to, and integration of, spirituality (Lewis et al., 2007). Religious beliefs and practices, such as reading the Bible, praying, and attending a place of worship, are ingrained in the culture and often used to cope with adverse health conditions (Dessio et al., 2004). Thus, African American men or women experiencing a physical or mental health condition may believe it is caused by disobedience to God and consult with their pastor or faith leader to get spiritual help.

Because of the significant associations among depression, psychological distress, chronic health conditions, and poor quality of life, efforts to adequately address mental health conditions in African Americans, women in particular, are imperative. African American women have high rates of morbidity and mortality related to other chronic health conditions, and the experience of depression or severe distress can further complicate their coping strategies and lead to significant yet preventable debilitation.

Despite the rich information from previous studies, other factors may influence mental healthcare use among African American women. The superwoman schema (SWS) conceptual framework was developed to clarify the connections between stress and health disparities among African American women: “The sociopolitical context of African American women’s lives, specifically the climate of racism, race- and gender-based oppression, disenfranchisement, and limited resources — during and after legalized slavery in the United States — forced African American women to take on the roles of mother, nurturer, and breadwinner out of economic and social necessity” (Woods-Giscombé 2010, p. 669). The framework includes five characteristics, four contributing contextual factors, three primary perceived benefits, and three primary perceived liabilities. The five characteristics are (1) perceived obligation to present an image of strength, (2) perceived obligation to suppress emotions, (3) resistance to being vulnerable or depending on others for help, (4) motivation to succeed despite limited resources, and (5) prioritization of caregiving over self-care. The four contributing contextual factors are (1) historical legacy of racial or gender stereotyping or oppression, (2) lessons from foremothers, (3) past history of disappointment, mistreatment, or abuse, and (4) spiritual values. The three perceived benefits are preservation of (1) self/survival, (2) the African American community, and (3) the African American family. Finally, the three perceived liabilities are (1) strain in interpersonal (e.g., romantic) relationships, (2) stress-related health behaviors (e.g., postponement of self-care, emotional eating, poor sleep), and (3) embodiment of stress (e.g., anxiety, depressive symptoms, and adverse health) (p. 672).

To develop the SWS conceptual framework, the research team conducted eight focus groups with a total of 48 African American women. Here, we report the results of a secondary analysis of the transcripts, guided by the five characteristics of SWS and the other components of the framework (e.g., contextual factors, perceived benefits, perceived liabilities), to identify critical information that can be integrated with existing knowledge about barriers to care and ultimately optimize health professionals' training and practice to sensitively address the needs of African American women.

METHODS

This project involved a secondary analysis of eight qualitative focus groups conducted with a demographically diverse sample of African American women to better understand SWS and its influence on coping and health in this population. A detailed account of the study design and methods has been published (Woods-Giscombe, 2010). The Institutional Review Board (IRB) of the sponsoring university approved the study methodology, briefly summarized here.

The focus group design followed the recommendations of Kitzinger and Barbour (1999) and Morgan and Krueger (1998). Participants were recruited from the local community through flyers placed at strategic locations, including a historically Black university campus, a community college, a women's health clinic, several government agencies (e.g., the health department), hair salons, libraries, African American women's civic organization meetings, a recreation center, and a cultural center. Interested women were asked to call study staff. They were screened for eligibility; participants were required to be African American women, aged 18 or older. A purposive sampling strategy was used to recruit women of various educational backgrounds.

Each group included women who were similar in age and education levels. Six out of the eight focus groups were composed of five to six participants. One had only two participants because several of those originally scheduled did not attend; this particular group was organized to include women between the ages of 18 and 25, who did not have any years of college education. Therefore, to capture the experiences of these women, an eighth focus group was scheduled, attracting 12 additional participants, for a total of 48 women. Focus groups were held in private rooms at community sites convenient for the participants. They were moderated by an African American woman in her thirties with graduate training in mental health (psychology and psychiatric nursing). In addition, a research assistant in her twenties with a background in psychology was present to distribute forms, refreshments, and other materials; she took detailed notes during the discussions. Focus groups were also digitally recorded and transcribed, and later, the author and research assistant confirmed the accuracy of the transcripts by comparing them to her notes. Participants were paid $30 for their time and provided refreshments during the two-hour session.

The informed consent process was reviewed with all participants, and they signed consent forms before the discussion started. The women were informed that participation was completely voluntary, and their identities would not be revealed in final reports on the study. Confidentiality was emphasized again prior to beginning each focus group interview.

Questions were openended and included: (a) When I say the word *stress*, what does it mean for you? (b) What causes stress in your life? (c) How do you cope with *stress*? (d) How did you see the women (mothers, grandmothers) in your life cope with stress? (e) Have you ever heard the term *strong black woman/black superwoman*? (f) What is a strong black woman/black superwoman? (g) What are her characteristics? (h) How did they develop? (i) Is being a strong black woman/black superwoman a good thing? (j) Is there anything bad about being a strong black woman/black superwoman?

Data Analysis

The secondary data analysis was conducted by a team of three researchers: two PhD-prepared members with expertise in health disparities and stress among African American women and one undergraduate research scholar with a background in psychology and African American studies. Applied thematic analysis (see Guest et al., 2012), guided by the characteristics of the SWS conceptual framework, was used to organize and describe implicit and explicit content from the focus group data. Team members first read the focus group transcripts to familiarize themselves with the data. Next, they worked independently to assign preliminary codes to the data. They then came together to discuss the patterns they identified and to share their thoughts about the preliminary codes. Next, the codes were confirmed, and the overarching themes identified and confirmed through discussions.

FINDINGS

The study sample has been described (Woods-Giscombe, 2010). Participants were demographically diverse, ranging in age from 19 to 72 years; the average age was 34 years. They had completed various levels of education; 18 percent had not completed the 12th grade; 10 percent had completed high school only; 17 percent had completed trade school, technical school, or an associate's degree; 18.8 percent had attended college but did not graduate; 17.4 percent had graduated from a 4-year university; and 14.6 percent had obtained a Master's or terminal professional degree. Most (64 percent) were employed, and less than half (40 percent) were current college students. Most were single (60 percent); 10 percent were married; 15percent were in a committed relationship; 15 percent were divorced, separated, or widowed. The median annual household income was between $26,000 and $50,000 (34 percent of the sample); and 41 percent of the participants earned less than $15,000 per year.

SWS Characteristics

Participants shared various accounts of how the superwoman role operates in their lives and how it might influence their use of mental health services. Results are presented in accordance with the five characteristics of SWS: an obligation to present an image of strength, an obligation to suppress emotions, resistance to being vulnerable or dependent on others, determination to succeed despite a lack of resources, and an obligation to help others instead of prioritizing selfcare.

Obligation to present an image of strength.—The perception that women must present an image of strength held across focus groups, as participants discussed their

experiences of emotional distress and help-seeking. Concerns about the stigma of weakness related to seeking mental healthcare were clearly linked to the desire to maintain an image of strength. Participants shared that they did not want society to perceive them as weak, despite the challenging experiences they face. All the groups related seeking psychotherapy to stigma. Although they had encountered circumstances that caused them extreme difficulty and distress, they did not view therapy as a viable option: "African American women do not go to therapy." Instead, they chose between suffering without assistance in a show of strength or finding an alternative way to cope to maintain the status quo in their respective communities. One participant said the mental illness stigma equated seeking mental healthcare with weakness rather than strength:

> But you commented on the therapy thing — I had something really traumatic happen to me last month, and my roommate was like, "You need to go to therapy." You tell that to a black woman, and it's like "Therapy?!" [laughs] You know what I mean? Like for the longest time, I thought therapy, number one, was for [pauses] white people. And number two was for weak people … like, why can't you conquer this yourself?

Some women in the focus groups shared positive perspectives on the perceived obligation to present an image of strength. The women who endorsed this characteristic stated that they were more equipped to deal with stress without becoming overwhelmed, and it gave them strength to know that they would be able to overcome any hardships that might come their way. However, women also acknowledged that feeling obligated to present an image of strength could facilitate sickness among African American women. Participants linked their personal beliefs about religion and faith as well as cultural expectations related to religion and faith to their desire to maintain a posture of strength. One noted:

> But it's a good thing because we don't let it — let stresses get us to the point where we give up on life. We just let it make us stronger, and knowing that there's always going to be a brighter day, and that if we — if it gets so bad, then we can always give it to God and let him handle it. I guess our faith is a lot stronger than other people's. I don't know why. And then it could be that … our stresses make us sick, make us have bad hearts and blood pressure and all that stuff that comes along with our black diseases or, not black diseases, but what affects us more anyway.

Another participant added:

> I agree with everything everyone has said about being a strong black woman. It can be good because, you know, you're determined. It's your motivation. It's what you look forward to. You know, that's something that you want to be called, but it's a downfall because when there's help, you don't ask for help, and then you wait till you get stressed, and, you know, what don't kills you makes you sick and when you become sick from un-necessary stress or struggles that you don't have to go through.

Focus group participants discussed cultural expectations to rely on religion rather than formal psychotherapy. They reported the notions of "giving a situation to God" or "God not putting more on an individual than he or she can bear." Their obligation to present an

image of strength was grounded in the idea that demonstrating strength to others was a proxy measure for degree of faith in God. Physically exhibiting emotional weakness might suggest that one's faith in God was not strong enough. One participant stated, "… our religious organizations dictate that you don't go for help." Participants reported that African American women may be more likely to pray about their circumstances and trust that God will fix them than to seek assistance from a mental healthcare professional.

Obligation to suppress emotions.—Women in the focus groups also expressed ideas about the links between seeking help for emotional distress and their perceived obligation to suppress emotions. They justified this obligation by describing how their caregivers — mothers and grandmothers, specifically — suppressed their emotions or frustrations. Others perceived the need to hold everything in no matter how difficult because their families and communities expected it and because they wanted to avoid being overwhelmed by their emotions. One participant shared:

> No, she [the therapist] wasn't the best, but she did open the doors to learning how to ask myself questions that I could try to process and figure out. And that was back then. But that didn't stop me from being the type of person that internalizes this thing. And I learned to do a lot of things, and I held them inside. And it's hard for me to break down … there's so much in there, that little bit of stream might come out in, like, … a trickle … even that was difficult for me for a long time. And I could feel it welling up, and then it'd go away. And it's like, "Oh God, I gotta get this solved, [laughs] or I might be dangerous," you know.

Others also shared concern about what would happen to them if they fully expressed their emotional distress to mental health professionals. They worried about what to disclose and what to withhold from them. One participant shared an experience involving miscommunication with her mental health service provider about a situation they were attempting to resolve. The problem led to a treatment involving medication that she did not feel she needed at the time. She also shared how her father had had a similar experience.

> That's another reason why I don't tell people because they start to think you're kinda going crazy! [laughs] So I don't. And my dad, he has really bad stress issues, and he's told the doctor about 'em. And he wasn't saying he was stressed out, but he was talking about some of the things that makes him angry and stressed out, and they put him on Zoloft-like, depression medicine. So you kind of got to watch what you tell people.

Focus group participants reported that they suppressed their emotions instead of seeking psychotherapy because of limited access to culturally sensitive providers. They did not feel that therapists had a keen understanding of the life experiences of African American women, that they lacked the compassion, patience, and competence needed to work optimally with African American women. Their disappointment with an inadequate therapeutic alliance caused some to conceal their feelings of distress instead of working through them with a therapist they did not trust. They were fully aware of the contrasts between their experiences and those of providers from a different racial or ethnic background. Participants commented on the difficulties they experienced when attempting to find a mental healthcare service

provider with whom they could identify. They shared feelings of disappointment when they were not able to find what they needed in a provider. One said:

> I agree with all the things that have been said so far … when I was working in the hospital, and somebody black would come in as a patient, an inpatient, they would be so relieved to see a black professional working with them, somebody who they thought could understand where they were coming from because they [people from other racial or ethnic groups] don't have a clue sometimes. They really don't. They try to, and they don't even know they don't have a clue. That's it.

Participants expressed genuine concern about mental healthcare service providers being compassionate and patient with them. Women across focus groups provided insight about encounters with previous service providers whom they perceived as impatient when an African American woman approached them for help because they did not understand her experience. On occasion, the women felt rushed and, in response, chose not to return for further therapy or treatment. Instead, they suppressed the emotions that were causing them difficulty. One said:

> Like just sitting there, watching them, it just don't seem like they care. I don't know. It's just, you know, like the last counselor I went to, she was just like, she seemed like she was kind of like rushing me, you know, and I felt like, you know, what I coming to you for? You're rushing me to get out of here — what's the point?

In addition to perceiving a lack of understanding of the SWS and a lack of compassion and patience among mental health professionals, focus group participants expressed concern about competence. Many noted that their mental healthcare service providers were not culturally competent to deliver the most efficient method of helping or treating them. They exhibited disappointment when telling their stories. As a direct consequence, some stated that they would not return to these providers because they were not helped in the ways they needed to be.

> Well, I wanted to seek help before. I thought that I was depressed. And then when I went there, and the woman — like you — if anything, I was helping her. [Laughter] I said, what's going on? I said, it doesn't make sense for me to come here. So to me, I don't feel that they — a lot of them can't help me. I have to help myself. I think cultural barriers or — I never went to a black psychologist, psychiatrist. But it was like she couldn't help me. She'd say, "Oh, my God."

As a consequence of suppressing their emotions, many women in the focus groups stated that they have experienced "breakdowns", becoming overwhelmed with the stresses of life. They stated that asking for help was considered a sign of weakness, so they would not ask for, or seek out, help when they probably should have. For example, one participant noted:

> I had a breakdown just because I started realizing that I have so much stuff, and I was overwhelmed, and I don't have anybody to help me. And I'm not a person to ask for help. I'm just so used to doing it all by myself 'cause I feel like if I don't do it, it's not going to get done.

Others shared that they suppressed emotions, except in environments where emotional expression was culturally sanctioned or considered acceptable. They recalled the common

practice of taking problems to the altar in church, which means handing problems and concerns over to God. Participants also recalled the biblical reference used to attest that God will not place more on a person than he or she can bear (Corinthians 10:13). The women felt more comfortable going to faith communities for healing than finding a mental healthcare provider due to cultural ideals.

> I totally agree about the breakdown. You do it in the seclusion of wherever you feel comfortable, and you just let it go. And it's like … I know, like you said you're a person who doesn't have like a church home. I'm like the same way. But you know, I pray about it 'cause my mom always says, "You have to pray about it," and I do it [clears throat] … I'll have a breakdown, I'll pray, and I'll just say, "Lord, make it better." And then eventually I know I have to get up off the floor and walk out the door and face the world again. So, you do it, and then you go.

Another participant added:

> And so when I do need to break down, that's where I break down [the altar at church]. Because everybody else is breaking down in there, too. And it's easier to go on and say, "Lord," in the house of the Lord, "you take this." I'm going to leave this here, I'm going to lay on the floor, and I'm going to cry. Nobody's going to laugh at me.

Resistance to being vulnerable or depending on others.—This theme was evident throughout each focus group. In the original literature on SWS (Woods-Giscombe, 2010), it was grounded in previous experiences of being let down, misunderstood, or unfairly judged by others who were expected to help. Disappointment related to receiving inadequate support led to a reluctance to trust new people to provide assistance and included mental health providers. Women may have heard anecdotes about what undesirable things might happen if they sought mental healthcare or have personally experienced situations that confirmed their concerns or mistrust.

Participants typically went to their pastor or minister as a mental healthcare provider. Consistent with the literature, they stated that African Americans commonly seek the help of a pastor or minister due to lack of trust of professional providers. They noted that their pastor or minister might be able to provide a comforting method of support, while acknowledging that clergy members might not be fully prepared to deal with the mental health problems and circumstances women face. One noted:

> I agree with you also. I think it's a culture barrier for us as black people. We always were told that we had to deal with it, and either go to your minister, or go to a family member, someone that you could trust and talk to. And then also, because of the stigma, as you stated earlier, it [cultural tradition] would say that you're crazy, you're weak, etc. Why in the world would any-one go to a therapist?

However, participants discussed the perceived limitations of going to the pastor for mental health support: "… and there are some things you can't be honest with your pastor about or just not reveal." One echoed a sentiment related to the risk of feeling misunderstood

or judged even by their clergy: "… and then we've learned that a lot of our pastors have problems too.… But they think *you* don't have faith."

Participants shared that because of mistrust and the fear of being vulnerable or misunderstood, they resisted depending on others and often tried to fix things and situations themselves, one participant stated "What doesn't kill you makes you stronger," an adaptation of Nietzsche's famous quote (*Twilight of the Idols*, 1889, Maxim and Arrows 8). Not having witnessed their mothers or caregivers express discomfort with life or present any indications of stress played a role in their resistance to dependence or vulnerability.

> We hold a lot in and try to fix it ourselves before we get help outside, but we hold a lot in and try to do it all by ourselves. And we don't, like —I'm not going to say we reach out for help more, but we'll say, okay, I'll do it by myself. I can do this by myself. I don't need your help.

Participants were still aware that, over time, this resistance may be a hindrance to receiving help when truly needed. They described how others saw them as independent, misinterpreting their need for assistance or support. One participant noted:

> I think it [strong Black woman ideology] comes with some bad. I mean, you always hear about—I feel like sometimes you have a tendency to be too independent … and you can turn people off from wanting to help you cause you're just so used to doing things on your own …

Determination to succeed despite a lack of resources.—Another component of SWS that seems to influence using mental health services is a determination to succeed despite limited resources. Focus group participants voiced their dedication to overcoming challenges in order to achieve their aspirations while acknowledging the costs. They believe you must be strong to get through situations because nothing comes easily. One woman shared:

> I agree. I really agree. To me when I'm going through something that's like really stressful, that's all that's repeating in my head: What doesn't kill you makes you stronger. And it reminds me like that in order to be great; you can't do the ordinary stuff … so that you can be stronger, you have to go through some stuff.

This way of thinking may cause women to overlook the symptoms of their emotional distress and identify them as necessary for being successful and great. As a result of minimizing their distress or its potential outcomes, they may delay seeking emotional support from mental health professionals.

Many said that when they were younger, they witnessed their mother figures or caregivers taking on tremendous life challenges with inadequate resources and pushing through emotional pain to achieve their goals. Participants were aware that they had assimilated these ideals. For example, one commented:

> I think it is because it goes all the way back to when …. Big Momma went through a struggle, so she taught her daughter how to handle that struggle, so she wouldn't

have to worry about it. And then so her daughter has a daughter, she teaches her daughter. It continues …

Obligation to help others over self-care.—Many participants stated that they have to balance several roles, which becomes difficult and overwhelming, but that they had no other options. They discussed prioritizing caregiving over self-care, which may result in delayed use or underuse of mental healthcare. One participant noted, "I feel like I have to be everything to everybody, and I'll come later on."

Some participants realized that their constant routine of caring for others while neglecting themselves could have undesirable consequences. They became overwhelmed and experienced what they referred to as breakdowns because they were not able to handle the situation and help themselves as a result of prioritizing others. One participant explicitly understood that therapy would help her but suppressed thoughts about helping herself in order to take care of what she perceived as the more urgent needs of others.

> I let myself have a breakdown twice a year, and I do that in privacy. I probably need therapy; I surely could use it. But it's just then, I don't know how my life would be if I wasn't like putting out fires all the time, that this just seems like that's just normal. That's just how it's going to be, and that's how it is. I just learned to deal with it.

DISCUSSION

This study used the SWS conceptual framework to identify barriers to mental health service use among African American women. A central aim was to explain ethnic disparities in mental healthcare in order to contribute to the development of culturally relevant mental health practices and services for African American women. Through applied thematic analysis of eight focus 23 group discussions, the research team was able to identify how the five characteristics of SWS influence attitudes and behaviors related to mental health and mental healthcare. Perceived obligations to appear strong, to suppress emotions, and to care for others, resistance to dependence/vulnerability, and determination to succeed despite a lack of resources overlapped with concepts identified in previous research on mental health service use among African American women (e.g., Gary, 2005; Hines-Martin, Malone, Kim, & Brown-Piper, 2003; Waite & Killian, 2008; 2009; Ward et al., 2013; Warren, 1994), including stigma, spirituality, and the desire for culturally sensitive providers. In general, these findings have important implications for research, education, and practice.

Focus group participants discussed the interconnections between the obligation to appear strong and the stigma of appearing weak, which have been discussed in the literature (Beauboeuf-LaFontant, 2007; Gary, 2005; Waite & Killian, 2008; 2009). Note that in the current study, participants identified three significant sources of stigma: seeking therapy, having a mental illness, and using medication.

Also corroborating the literature (e.g., Ward & Heidrich, 2009; Ward, Wiltshire, Detry, & Brown, 2013), spirituality was found to be an important aspect of the African American cultural experience and closely related to the perceived obligation to appear strong, suppress

emotional distress, and resist dependence on mental health professionals. Focus group participants discussed cultural expectations for spirituality/religion, pastoral counseling and/or the minister as therapist, prayer, and relieving emotional distress at the altar or in church, where it was considered acceptable. These cultural expectations influenced their views about using mental healthcare services. African American women use religion and spirituality to counter the negative effects of stressful circumstances (Ward & Heidrich, 2009). Among focus group participants, cultural expectations related to giving a problem to God or God not putting more on us than we can bear served as a barrier to accessing mental healthcare. The appearance of strength is a proxy for degree of faith in God.

The theme of culturally sensitive providers was another important component of participants' decisions about mental healthcare services. Many of the women had experienced service providers who did not understand the complexities or social contexts of their lives or seemed lacking in compassion, patience, or cultural sensitivity and competence. The result was frustration with therapy and a conscious decision not to return. Some participants who had never received therapy reported a reluctance to start because they were concerned that the therapist would not understand or know how to support them.

Women connected the concepts of spirituality and culturally sensitive providers. They shared the cultural expectation and tendency to use pastoral counseling or their ministers as therapists in times of distress. They discussed how they used prayer to overcome emotional strain and their tendency to "take it to the altar," or to express emotional distress in church, as a more culturally sanctioned behavior than expressing distress to mental healthcare professionals (see Ward et al., 2014). These women found strength in God to solve their problems. They found comfort in spirituality/religion because they felt it provided the only place in which they would receive the assistance that would truly heal them. However, some noted that although comforting, clergy may not be fully equipped to provide psychotherapeutic support.

The findings from this study corroborate reports from previous researchers (see Waite & Killian, 2008; 2009). The socially constructed image of the "strong black woman" may be associated with increased symptoms of anxiety and depression, lower availability of emotional support, and less self-perceived need for formal or informal mental health assistance (Matthews & Hughes, 2001; Watson & Hunter, 2015). African American women cope through such culturally sanctioned behaviors as religious practices and resilience, which may serve as barriers to seeking professional mental healthcare (Ward et al., 2014).

Advantages and Limitations

Other conceptual frameworks (e.g., the common-sense model, the health belief model, and Kleinman's explanatory model of illness) have been used to understand African American women's perceptions, beliefs, and attitudes about mental health and using mental health services (see Waite & Killian, 2008; 2009; Ward, Clark, & Heidrich, 2009). However, this study is the first to apply the SWS conceptual framework, specifically developed to address the intersection of race and gender, to clarify African American women's perspectives on, and experience of, mental healthcare. It provided contextual richness by focusing on culturally driven and gender-specific phenomena. In addition, study participants represented

a range of educational and income backgrounds and a broad age range. However, the fact that they all live in the southeastern United States is a limitation. Findings may have differed if they had come from a variety of geographic regions. Also, because of the cross-sectional design, findings should be interpreted cautiously to consider how perceptions, beliefs, and attitudes may change as a result of new experiences and insights.

Implications for Practice

In clarifying African American women's views of mental healthcare, these findings can enhance training programs for service providers as well as faith leaders from whom African American women may be more likely to seek assistance, and providers should be aware of the potential benefits of developing treatment plans that consider a woman's religious preferences and traditions. They should make an effort to become more sensitive to, and aware of, African American culture and the experiences and perspectives of African American women to better serve these clients (Jones & Guy-Sheftall, 2015). While achieving racially or ethnically concordant provider/patient matching may not be possible, having more ethnically diverse individuals providing care is desirable. In any case, all providers should be culturally sensitive to ensure the progress and well-being of their patients.

Implications for Education

Health professions faculty should be well-versed in the factors that contribute to mental health disparities and inequities in service provision and use among diverse populations, so they can address them in their courses and didactic and clinical training of future health professionals. This content is critical for programs that train both mental health professionals and primary care providers, who treat most mental health disorders; the reasons for approximately 20 percent of all visits to primary care providers are screening for depression, counseling, prescription of a psychotropic medication, or a mental health diagnosis (Olfson, Kroenke, Wang, & Blanco, 2014; Kennedy Forum, 2015). In addition, nearly 70 percent of all primary care visits are influenced by psychosocial factors (Robinson & Reiter, 2007). Including the SWS conceptual framework, information about the social determinants of health, and the Surgeon General's 2001 report would provide a good foundation for a modified, culturally relevant curriculum. Stigma, spirituality, and ethnic-specific-considerations relevant to prescribing medications (ethnopsychopharmacology; see Campinha-Bacote, 2007) should also be addressed.

Implications for Future Research

The findings of this study open several avenues for future research. First and foremost, the field needs nationally representative, current, comprehensive epidemiological data on ethnic and gender differences in mental health conditions and service use. The following key variables should be considered: geographic region (including urban versus rural setting), demographics (age, education, income status), symptoms of mental health conditions versus actual diagnosis, the modifying influence of health insurance status, and various treatment modalities and strategies (private psychotherapy practice, primary care, community health agencies, faith-based counseling, hospitalization). Without research-based evidence, insufficient and conflicting reports about rates of mental health conditions and

care across diverse sectors will continue. Future research should examine the extent to which health professions education that includes content on mental health disparities and the factors that influence service use improves outcomes.

The findings from this study might be applied to other underrepresented racial or ethnic groups who experience health disparities — Native Americans or Hispanic/Latino Americans. The focus group discussions of religion and spirituality largely represented a Christian worldview. Future research should examine whether relationships among spirituality, mental health stigma, and use of mental healthcare services are similar among African American women who are not grounded in Christianity.

Finally, study findings support the literature that addresses the importance of developing and implementing culturally tailored approaches (see Ward, 2005; Ward & Brown, 2015); epistemological approaches; "ways of knowing" and experiencing life (see Banks Wallace, 2000, p. 33; Jones & Guy-Sheftall, 2015) that may enhance health-promoting behaviors and the initiation, retention, and quality of mental healthcare for African American women.

Summary

In summary, factors that contribute to African American women's underuse of mental health services include SWS characteristics: the obligation to present an image of strength and to suppress emotions; resistance to vulnerability or dependence on others; motivation to succeed despite limited resources; and prioritization of caregiving over self-care. Contributing factors discussed in the literature include stigma, spirituality, and culturally sensitive providers. Researchers, educators, and providers must understand these factors, so this population will access services and practices that promote their health.

REFERENCES

Alegría M, Chatterji P, Wells K, Cao Z, Chen C, Takeuchi D, … Meng X (2008). Disparity in depression treatment among racial and ethnic minority populations in the United States. Psychiatric Services, 59(11), 1264–1272. doi:10.1176/appi.ps.59.11.1264 [PubMed: 18971402]

Banks-Wallace J (2000). Womanist ways of knowing: Theoretical considerations for research with African American women. Advances in Nursing Science, 22, 33–45. [PubMed: 10711803]

Brown C, & Palenchar D (2004). Treatment of depression in African American primary care patients. African American Research Perspectives, 10, 55–65.

California Black Women's Health Project. (2003). Healing for the mind, body & soul. News notes from California Black women's health project Retrieved May 15, 2005, from http://oldsite.cabwhp.org/pdf/oct2003.pdf

Campinha-Bacote J (2007). Becoming culturally competent in ethnic psychopharmacology. Journal of Psychosocial Nursing and Mental Health Services, 45, 27–33.

Centers for Disease Control and Prevention. (2012). Health Statistics for US Adults: 2010. Table 14. Retrieved July 5, 2016, from http://www.cdc.gov

Copeland VC, & Snyder K (2010). Barriers to mental health treatment services for low-income African American women whose children receive behavioral health services: An ethnographic investigation. Social Work in Public Health, 26, 78–95. doi:10.1080/10911350903341036

Dessio W, Wade C, Chao M, Kronenberg F, Cushman LE, & Kalmuss D (2004). Religion, spirituality, and healthcare choices of African American women: Results of a national survey. Ethnicity and Disease, 14, 189–197. [PubMed: 15132203]

Gary FA (2005). Stigma: Barriers to mental health care among ethnic minorities. Issues in Mental Health Nursing, 26, 979–999. [PubMed: 16283995]

Guest G, & MacQueen KM (2012). Applied thematic analysis. Los Angeles: Sage Publications.

Hines-Martin V, Malone M, Kim S, & Brown-Piper A (2003). Barriers to mental healthcare access in an African American population. Issues in Mental Health Nursing, 24, 237–256. [PubMed: 12623684]

Holden KB, Bradford LD, Hall SP, & Belton AS (2013). Prevalence and correlates of depressive symptoms and resiliency among African American women in a community-based primary health care center. Journal of Health Care for the Poor and Underserved, 24, 79–93. [PubMed: 24241263]

Jones LV, & Guy-Sheftall B (2015). Conquering the Black Girl Blues. Social Work, 60, 343–350. [PubMed: 26489355]

Kennedy Forum. (2015). Fixing behavioral health care in America: A national call for integrating and coordinating specialty behavioral health care with the medical system. Retrieved July 5, 2016, from http://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-BehavioralHealth_FINAL_3.pdf

Kitzinger J, & Barbour RS (1999). Developing focus group research: Politics, theory, and practice. London: Sage.

Leis JA, Mendelson T, Perry DF, & Tandon SD (2011). Perceptions of mental health services among low-income, perinatal African American women. Women's Health Issues, 21(4), 314–319. doi:10.1016/j.whi.2011.03.005 [PubMed: 21712144]

Lewis LM, Hankin S, Reynolds D, & Ogedegbe G (2007), African American spirituality: A process of honoring God, others, and self. Journal of Holistic Nursing, 25(1), 16–23. doi:10.1177/0898010106289857 [PubMed: 17325309]

Masuda A, Anderson P, & Edmonds J (2012). Help-seeking attitudes, mental health stigma, and self-concealment among African American college students. Journal of Black Studies, 43(7), 773–786. doi:10.1177/0021934712445806

Matthews AK, & Hughes TL (2001). Mental health service use by African American women: Exploration of subpopulation differences. Cultural Diversity and Ethnic Minority Psychology, 7(1), 75–87. doi:10.1037/1099-9809.7.1.75 [PubMed: 11244906]

Miranda J, & Cooper LA (2004). Disparities in care for depression among primary care patients. Journal of General Internal Medicine, 19, 120–126. [PubMed: 15009791]

Moore JL, & Madison-Colmore O (2005). Using the H.E.R.S. model in counseling African American women. Journal of African American Studies, 9(2), 39–50. doi:10.1007/s12111-005-1021-9

Morgan DL, & Krueger RA (1998). The focus group kit. Volumes 1–6. London: Sage.

National Alliance for Mental Illness. (2008). Women and Depression. Retrieved July 5, 2016, from http://www.nami.org/Press-Media/Press-Releases/2008/Women-Depression-1-in-8;-twicethe-rate-of-men

National Institute of Mental Health. (2016). Depression. Retrieved January 16, 2016, from http://www.nimh.nih.gov/health/statistics/index.shtml#Intro

Olfson M, Kroenke K, Wang S, & Blanco C (2014). Trends in office-based mental health care provided by psychiatrists and primary care physicians. Journal of Clinical Psychiatry, 75, 247–53. [PubMed: 24717378]

Pratt LA, & Brody DJ (2014). Depression in the US Household Population, 2009–2012. NCHS Data Brief No. 172, December 2014. Retrieved July 5, 2016, from http://www.cdc.gov/nchs/data/databriefs/db172.htm

Robinson P, & Reiter J (2007). Behavioral Consultation and Primary Care: A Guide to Integrating Services. New York: Springer.

Stevens-Watkins D, Perry B, Pullen E, Jewell J, & Oser CB, (2014). Examining the associations of racism, sexism, and stressful life events on psychological distress among African-American women. Cultural Diversity & Ethnic Minority Psychology, 20, 561–569. [PubMed: 25313434]

Thompson-Sanders VL, Bazile A, & Akbar M (2004). African Americans' perceptions of psychotherapy and psychotherapists. Professional Psychology: Research and Practice, 35(1), 19–26.

United States Department of Health and Human Services. (2001). Mental health: Culture, race, and ethnicity. A supplement to mental health: A report of the Surgeon General Rockville, MD: Author.

US Burden of Disease Collaborators. (2013). The state of US health, 1990–2010: Burden of diseases, injuries, and risk factors. JAMA, 310(6): 591–608, 2013. [PubMed: 23842577]

Waite R, & Killian P (2008). Health beliefs about depression among African American women. Perspectives in Psychiatric Care, 44,185–195. [PubMed: 18577124]

Waite R, & Killian P (2009). Perspectives about depression: Explanatory models among African American women. Archives of Psychiatric Nursing, 23, 323–333. [PubMed: 19631110]

Ward EC (2005). Keeping it real: A grounded theory study of African American clients engaging in counseling at a community mental health agency. Journal of Counseling Psychology, 52, 471–481.

Ward EC, & Brown RL (2015). A culturally adapted depression intervention for African American adults experiencing depression: Oh Happy Day. American Journal of Orthopsychiatry, 85, 11–22. [PubMed: 25420141]

Ward E, Clark L, & Heidrich S (2009). African American women's beliefs, coping behaviors, and barriers to seeking mental health services. Qualitative Health Research, 19(11), 1589–1601. doi:10.1177/1049732309350686 [PubMed: 19843967]

Ward E, Mengesha M, & Issa F (2014). Older African American women's lived experiences with depression and coping behaviours. Journal of Psychiatric and Mental Health Nursing, 21(1), 46–59. doi:10.1111/jpm.12046 [PubMed: 23742034]

Warren BJ (1994). Depression in African American women. Journal of Psychosocial Nursing and Mental Health Services, 32, 29.

Watson NN, & Hunter CD (2015). Anxiety and depression among African American women: The costs of strength and negative attitudes toward psychological help-seeking. Cultural Diversity & Ethnic Minority Psychology, 21, 604–612. [PubMed: 25602466]

Williams CB, & Wiggins MI (2010). Womanist spirituality as a response to the racism-sexism double bind in African American women. Counseling and Values, 54(2), 175–186.

Williams DR, Gonzalez HM, Neighbors H, Nesse R, Abelson JM, Sweetman J, & Jackson JS (2007). Prevalence and distribution of major depressive disorder in African Americans, Caribbean Blacks, and Non-Hispanic Whites: Results from the National Survey of American Life. Archives of General Psychiatry, 64, 305Y315. [PubMed: 17339519]

Wisconsin Minority Health Program. (2004). Minority health report: The health of racial and ethnic populations in Wisconsin: 1996–2000. Retrieved November 12, 2007, from http://dhs.wisconsin.gov/Health/MinorityHealth/Report.htm

Woods-Giscombé CL (2010). Superwoman Schema: African American women's views on stress, strength, and health. Qualitative Health Research, 20(5), 668–683. doi:10.1177/1049732310361892 [PubMed: 20154298]

Woods-Giscombé CL, & Lobel M (2008). Race and gender matter: A multidimensional approach to conceptualizing and measuring stress in African American women. Cultural Diversity and Ethnic Minority Psychology, 14, 173–182. [PubMed: 18624581]

Woods-Giscombe CL, Lobel M, Zimmer C, Cene C, & Corbie-Smith G (2015). Whose stress is making me sick? Network-stress and emotional distress in African American women. Issues in Mental Health Nursing, 36, 710–717. [PubMed: 26440874]

T305 – Supporting Black Women in Mental Health: Culturally Responsive Practices for Clinicians

https://pmc.ncbi.nlm.nih.gov/articles/PMC8020496/

https://www.bu.edu/articles/2023/racism-sexism-and-the-crisis-of-black-womens-health/

https://nwlc.org/resource/social-determinants-of-health-metrics-for-black-women-by-state/

https://www.hopkinsmedicine.org/health/wellness-and-prevention/mental-health-among-african-american-women

https://pmc.ncbi.nlm.nih.gov/articles/PMC7544187/

https://www.psychiatrictimes.com/view/the-state-of-mental-health-of-black-women-clinical-considerations