

BRK Global Healthcare Journal, 978-1-5323-4858-7

Volume 2, Issue 1, 2018

African American Women and Depression: Promoting the Need for Culturally Competent Treatment

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Abstract

Depression is gradually increasing in African American women. These women are experiencing role changes and additional life stressors. Depressed African American women may perceive themselves as being devalued by society with fewer support systems to buffer stressful events. Depressive symptoms may develop into clinical depression and a further decrease in the quality of life for the African American woman. The assumption that all women share similar experiences does not allow for differences to emerge regarding the diagnostic process, measuring tools, and successful treatment strategies for various cultures. The authors developed a *Multifaceted Model of Depression in African American Women* for improving treatment of African American women with depression and future research needs. Cultural background plays a vital role in how the symptoms of mental illnesses are developed, reported, interpreted, and how women are treated. African Americans who subscribed to the Strong Black Women Archetype (SBWA) are naturally strong, resilient, self-contained, and self-sacrificing. This self-reliance prevents them from reaching out for social support. This, in turn, can contribute to depressive symptoms with negative health outcomes. The African American women are more apt to have less access to routine medical care where early diagnosis and interventions can be done, so their mental health problems (e.g., depression, stress, etc.) are often more developed, complicated, and their social supports more depleted when they do access treatment. When African American women do have access to mental health care, they receive poor quality care compared to Whites.

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Key Words: African American Women, depression; Strong Black Women Archetype; disparities; health promotion; health disparities; diagnosis; stress; social support; coping; health outcomes.

Often, African American women may be misdiagnosed because they go to health care visits looking well- groomed regardless of feeling depressed or sad. As a result, health professionals often see their appearance as well-groomed, not disheveled during their assessment. When assessing African American females, they often deny feeling depressed because they don't want to be seen as weak or not spiritually strong. In the African American culture, common phrases of African American women when referring to their health problems are "I am not going to claim it" or "I'm bless" (*Dr. Bernice Robert Kennedy*)

In the African-American culture some women tend to adopt a Strong Black Woman archetype. This persona is passed down from several generations of SBW's and reinforced by current social conditions. African American women's adoption of the Strong Black Woman identity incites a tendency toward self- reliance which may prevent them from reaching out for social support. As a result, African American women may adopt a superwoman mentality, which further maintains their isolation. This cultural phenomenon can contribute to depressive symptoms.
(*Dr. Chalice C. Jenkins*)

Overview

A lack of both diagnostic and treatment studies has historically plagued the handful of studies regarding African American Women and depression (Sohail, Bailey & Richie, 2014). A substantial gap exists in the literature relative to the studies of depressed African American women and their children (Boyd & Waanders, 2013). They experience a disproportionate share of environmental and life stressors, which significantly increases their vulnerability to depression (Goodman et al. 2011; Riley et al. 2009). More recently, clinical depression amongst African American women is 50% greater than Caucasians (Zauszniewski, Picot, Debanne & Roberts, 2002). African Americans also experience a longer duration of depression at 56.5% compared to 56% for Caribbean blacks and 38.6% for Caucasians (Sohail et al., 2014). The rates have reversed due to the fact that many African American women were not diagnosed as being depressed.

African American women experience racism, sexism, and poverty (Sohail et al., 2014). Depressed African American women may perceive themselves as being devalued by society and with fewer support systems to buffer stressful events (Sue & Sue, 2005). Depressive symptoms may develop into clinical depression and a further decrease in the quality of life for the African American woman. The assumption that all women share similar experiences does not allow for differences to emerge regarding the diagnostic process, measuring tools, and successful treatment strategies for various cultures (Coridan & O'Connell, 2002).

African American women are at risk than their white counterparts for experiencing stress and negative outcomes in areas such as health, education, and psychological well-being (Kennedy, 2009a; Kennedy, 2010). The effects of these oppressive conditions include seriously distorted view of self and others, feeling of hopelessness, and over-reliance on maladaptive strategies and isolation (Jones, 2002). African American women have higher prevalence rates of depression, anxiety, and phobia than African American men (Robins & Regier, 1991).

African American women experience multiple problems in their lives because they contend with issues of gender, race, and class (Collin, 2000). They encounter discrimination both within and outside their communities. African American women may experience racism from other women, as well as men. The influence of both gender and race broadly impacts the personal development of black women (Brown & McNair, 1995; Collin, 2000).

Often, African American women are hindered by fewer years of education, a higher rate of unemployment, over-representation in low-status, low-paying jobs, and significantly higher rate of poverty than those of white and black men (Miranda et al., 2003). Within the professional realms, they are under-represented in the position of power and generally are denied sufficient access to necessary social and material resources (Miranda et al., 2003). Black women tend to suffer poorer mental and physical health outcomes than other ethnic groups, regardless of their socioeconomic status (Jones, 2003).

Incidence and Prevalence

Currently, depression affects approximately 19 million adults every year in the United States (NMHA, 2018). Approximately, 12 million women in the United States experience clinical depression (NMHA, 2018), and the rate among African American women is (50%) higher than white women (Zauszniewski et al., 2002).

African Americans account for approximately (25%) of the mental health needs in this country, though they only make up (11 to 12%) of the national population, and only (2%) of mental health psychiatrists are African Americans (NMHA, 2018). The prevalence of mental disorders is estimated to be higher among African Americans than among White Americans. This disparity is more likely due to economic differences. They are under-represented in some private outpatient

population, over-represented in some inpatient population, and more likely than White Americans to use the emergency room for mental treatment. African Americans drop out of services at a significantly higher rate than whites and use fewer treatment sessions for mental services (Coridan & O'Connell, 2002). They enter treatment at a later, more advanced stage than White Americans, access at a low rate of community mental health services, and misdiagnosed with a severe mental illness than White Americans (Coridan & O'Connell, 2002). Often, African Americans are often misdiagnosed and undertreated in the conventional healthcare system (Sohail et al., 2014). Clinical research on African American women has been scarce (Coridan & O'Connell, 2002). This scarcity in clinical research is because usually, African American women do not seek treatment for their depression (Coridan & O'Connell, 2002). In addition, they are often misdiagnosed or may have withdrawn from treatment because their ethnic, cultural, or gender needs are not being met. Often, they do not participate in research studies because they are uncertain as to how research data will be disseminated, or they are afraid that the data will be misinterpreted (Carrington, 2006). African American women, also, are less available to participate in depression research studies resulting in limited empirical data of research findings to improve treatment.

Historical Perspective

At the beginning of the 21st century, African American women found themselves achieving new heights and reaching new milestones (Sue & Sue, 2005). Education and hard work enabled them to achieve a successful career and respect in mainstream society. Despite this news, African American women still find themselves lagging behind white women and other women in health and mental health. In addition, African American women experience a role of conflict between their professional development, personal development, and family responsibilities. Feeling guilty for the time taken away from their roles as mothers and homemakers contribute to depression (Sohail, et al., 2014). There is a struggle to balance the multiple roles of African American women juggle.

Historically, African American women maintain a consistent manifestation of strength while suppressing emotion, masking difficulties, and abiding by the cultural mandate of silence (Woods-Giscombé, 2010). The *Strong Black Woman (SBWA) Archetype* is a culture model that describes the norms for the African American women for thinking, feeling and behaving as rooted in their historical experience in Africa (Abrams et al., 2014; Beauboeuf-Lafontant, 2009; Hamin, 2008; Woods, 2013; Woods-Giscombé, 2010). This model prescribes the ideal of African American women characteristics as self-reliant, selflessness, psychological, emotional, and physical strength (Watson & Hunter, 2015).

SBWA portrays African American as nurturing, resilient, and, resistant to being dependent on or vulnerable to psychological or physical challenge (Woods, 2013). This model has been used as a cognitive framework in guiding African American women in structuring and formatting experiences in their lives.

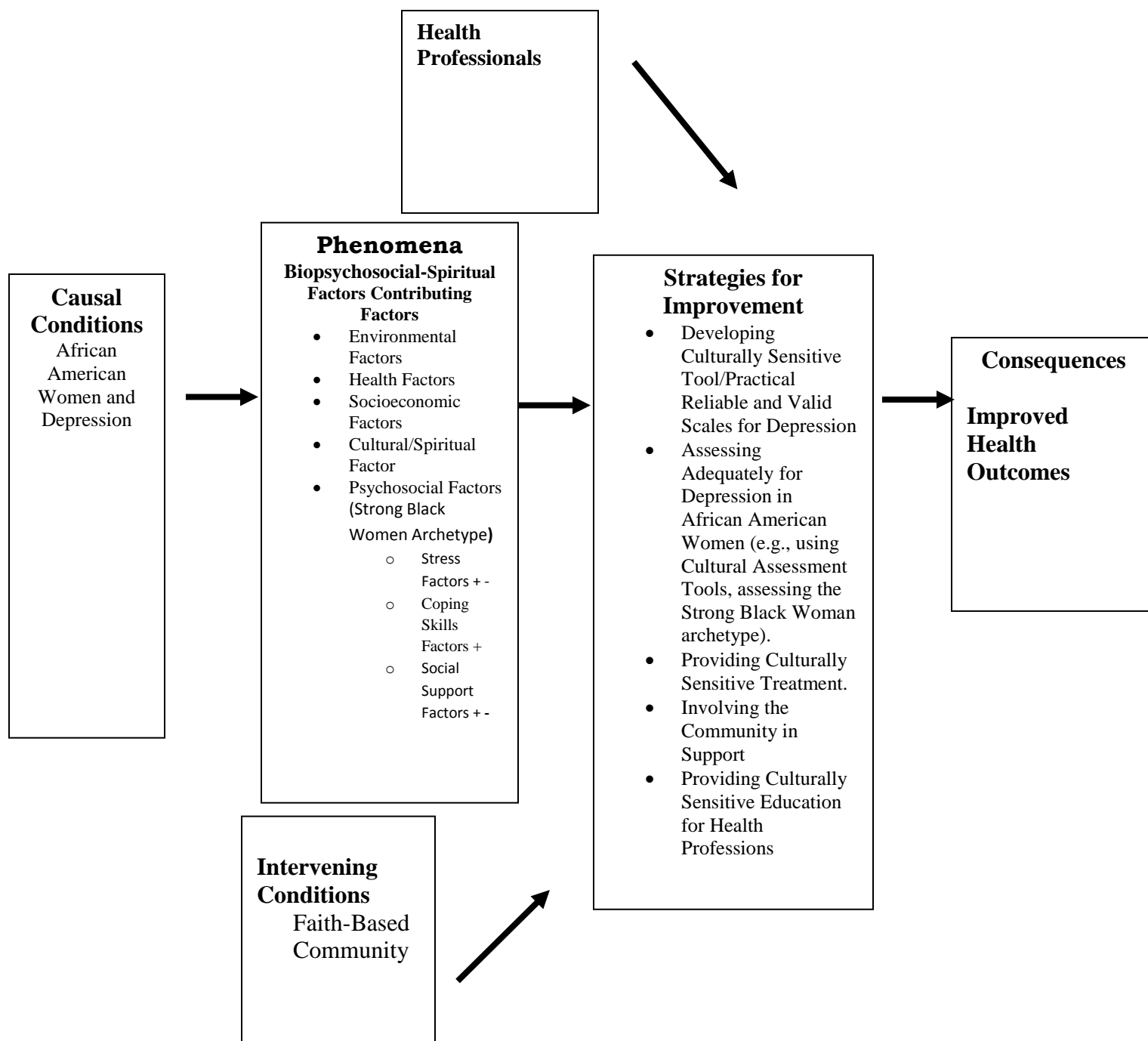
Historically, African American women had numerous challenges associated with various struggles, forms of oppression and negative character stereotypes (Watson & Hunter, 2015). These character stereotypes impacted African American women's social well-being. The SBWA has been dated back to slavery describing their coping mechanism in dealing with oppression by developing in a strong, less traditionally female role (Watson & Hunter, 2015). Scholars traced this SBWA which have originated from slavery from generation to generation. African American women continue to experience challenges such as financial hardship, primary caregiving responsibilities, racism, and sexism.

Today, African American women continue to take pride in being superwomen to resist against the intersectionality of being both black and female in society (Woods-Giscombé, 2010). African American women are praised for their resilience and strengths in holding her family together, working harder than others and keeping her house (Baker et al., 2015). However, African American women experience tensions in maintaining this superwomen image contributing to depression.

Multifaceted Model of Depression in African American Women

The authors developed a model for conceptualizing depression and culturally competent treatment in African American women. This model is useful in depicting the impact of the biopsychosocial-spiritual factors contributing to depression and the need for culturally competent treatment of African American women. These factors will be discussed individually.

Figure 1: Multifaceted Model of Depression in African American Women



Biopsychosocial-spiritual Factors

Health professionals working with African American women need to be aware of the biopsychosocial-spiritual factors contributing to depression in African American women. (Kennedy, 2009a; Kennedy, 2009b; Kennedy, 2010; Kennedy, 2015; Kennedy, Mathis, & Woods, 2007). Biopsychosocial-spiritual factors affect depression and health outcomes of African Americans (Kennedy, 2009a; Kennedy, 2009b; Kennedy, 2010; Kennedy, Mathis, & Woods, 2007). There are some experiences similar in this group; however, individual makeup needs to be considered. In the model, biopsychosocial-spiritual factors affecting depression in African American women are as follows: (a) environmental factors, (b) socioeconomic factors (SES), (c) health factors, and (d) cultural factors. Psychosocial factors influencing positive or negative outcomes of African American women with depression are (a) stress factors, (b) coping factors, and (c) social support factors

Environmental Factors

Overall, environmental factors have contributed to the mental health problems (e.g. depression, stress, etc.) of African American women, such as racism in society (Giurgescu et al., 2015; Kennedy, 2009a; Kennedy, 2010; Kennedy, 2015; Kennedy, Mathis, & Woods, 2007). Racism permeates the culture and economy of this country and is the main barrier to mental health care for black Americans (Kennedy, 2009a; Primm, 2008). The system creates economic disparities and social conditions that are truly distressing. Many African Americans living in poverty reside in areas beset by alcohol outlets, open-air drug markets, high incarceration rates, high rates of homelessness, and large numbers of children in foster care without permanent homes. These conditions have a major impact on their mental health (Primm, 2008).

African Americans may perceive factors in their environment, such as substandard housing, living in areas of health hazards (e.g., landfills; contaminated water supplies, etc.), fewer years of education, lack of skilled labor and managerial jobs, and over-representation in low paying jobs, living in drug infested and violence communities and other ethnic discrimination as racism which may cause depression, stress, etc. (Kennedy, 2009a; Kennedy, 2009b; Kennedy, 2015; Kennedy Mathis & Woods, 2007).

Racism in the United States resulted in negative outcomes for African American females. Their stressful living conditions such as poverty, discrimination, racism, abuse, and rejection from American society may contribute to their thoughts of suicide (Black, 2003). The lifestyles of African American women have been influenced by poverty and prior injustices, which have molded their worldview of health and illness (Kennedy, 2009a; Kennedy, 2009b; Kennedy, 2015; Kennedy, Mathis, & Woods, 2007)

Socioeconomic Factors

African American women are more likely than Caucasian women to share a high level of socioeconomic risk factors for depression. (Hudson, Neighbor, Geronimus, & Jackson, 2016). Some socioeconomic factors that contribute to depression are as follows: (a) racial/ethnic discrimination; (b) lower education and income level; (c) segregation into low status; (d) high job stress; (e) unemployment; (f) poor health; (g) large family sizes; (h) marital dissolution; (i) single parenthood; and (j) low self-esteem (Belle & Doucet, 2003; Jesse, Walcott-Quigg, & Swanson, 2005, Martin, 2003; McGrath, Keita, Strickland & Russo, 1990). They find themselves at the lower spectrum of the political and economic continuum. African American women are involved in multiple roles in their struggle to survive economically, and advance their roles in their workplace and their families through the mainstream of society (Kennedy, Mathis, & Woods, 2007). Often, these socioeconomic factors intensify the stress in their lives, which erodes their

self-esteem and social systems and health (Warren 1995). Regardless of their socioeconomic status, African American women tend to suffer poorer mental and physical health outcomes than other ethnic groups (Brown & McNair, 1995; Kennedy, 2009a; Kennedy, 2009b). A recent study by Hudson et al. (2016) found greater levels of education were positively associated with racial discrimination and increased levels of racial discrimination were positively related to depression controlling for all sociodemographic factors.

African American women in the United States experience tremendous challenges related to their double status as being the strong, black and female (Watson & Hunter, 2015). The exact incidences of depression in black women are unclear because of the controversy regarding misdiagnosis and lack of clinical research.

Health Factors

African American women have numerous medical problems, in addition to a higher incidence of depression (Bender, 2005). Common health problems in African American women associated with depression are cardiovascular disorder, stroke, diabetes, cancer, and obesity (Bender, 2005; NIMH, 2018). Among African Americans especially, symptoms of depression are associated with increased risk of hypertension (Pickering, 2000). Also, depression coexists with medical conditions such as heart disease, stroke, cancer, HIV/AIDS, diabetes, Parkinson's disease, thyroid problems, and multiple sclerosis. In addition, depression coexisting with these medical conditions may make these conditions worse (NIMH, 2018). The intensity and frequency of depression are highest in the more severely ill clients. Research has revealed a high incidence of depression among hospitalized patients with serious medical conditions (NMHA, 2018). Often, these depressive symptoms are unrecognized and thus are untreated by health professionals (NMHA, 2018). Research has shown that persons having depression with a serious medical condition tend to have more severe symptoms of both. These coexisting illnesses impact on positive outcomes such as patients adapting to their medical conditions and an increase in medical cost (NIMH, 2018).

Depression often coexists with other mental health disorders such as eating disorders e.g., anorexia nervosa, bulimia nervosa (NIMH, 2018). Also, anxiety disorders such as post-traumatic stress disorder (PTSD), obsessive-compulsive disorder, panic disorder, social phobia, and generalized anxieties are associated with depression in women. Women are more prone than men to have coexisting anxiety disorders (NIMH, 2018). African American women often eat or drink heavily to overcome their emotions (Black, 2003). Obesity may contribute to the developing of depression in African American women. There is a negative association between obesity and mental well-being (Bender, 2005). In addition, minority women are more likely to have depression and PTSD. A strong link exists between PTSD, misuse, use of abuse of drugs, alcohol, and other drugs to include tobacco (Coridan & O'Connell, 2002).

Culture Factors/Spiritual Factors

Culture plays an important role in the development of depression in African American women (Amankwaa, 2003). Also, there is a stigma associated with seeking mental and emotional health that prevents many African American women from admitting they are struggling with mental health issues (Black, 2003). Historically, mental health has been viewed as demonic or evil in the African American community (Amankwaa, 2003). Typically, African Americans suffering from mental health problems may not seek or access the mental health system. In some cultures, root doctors are the preferred treatment or religious leaders for spiritual interventions (Kennedy, 2009a). Often, African Americans will seek treatment from the community or a religious leader rather than a mental health professional (Coridan & O'Connell 2002; Kennedy, 2009a).

Traditionally, mental health services have not been sensitive to ethnic differences in the ways their clients (e.g., African Americans) recognize, define, and express symptoms of emotional distress (Mills, 2000). When African American women enter the health care system, their cultural presentation of self and reporting information to health providers of different races may be misinterpreted (Barbee, 1992). The misinterpretation of the information provided may lead to inappropriate diagnosis and treatment interventions.

African American women tend to look at mental health treatment (e.g., therapy) as a sign of weakness (Kennedy, 2009a). They present themselves to society as strong, resilient individuals. These characteristics are ingrained in the culture of African American women and can be traced back to slavery. Often, African American women pretend she is okay when she is actually suffering inside (Black, 2003; Kennedy, 2009a).

In some cultures, African American women feel they need to pray and keep the problems within the black community (Black, 2003; Kennedy, 2009a). They feel that they are not being the strong black women if they admit having a problem and telling a stranger about their problems (Black, 2003; Kennedy, 2009a).

African Americans often mistrust the mental health professionals based on history due to higher than average institutionalization of African Americans with mental illness (Coridan & O'Connell, 2002; Kennedy, 2009a). There is a stigma associated with seeking mental and emotional health that prevents many African women from admitting they are struggling with issues. Less than (10%) of African Americans suffering from depression seek help. Cultural barriers, including the presentation of the symptoms, may influence language and behavior mannerisms (Barrow, 2003).

The negative perception of mental health services contributes to African Americans underutilization of mental health services (Mayo, 2004; Watson & Hunter, 2015). Often, African Americans believe that even when they have insurance coverage, white health providers do not want to treat them and will only give them pills that will make them worse (Mayo, 2004). African Americans only go to psychiatrists when they feel they are "really crazy." Being crazy is a stigma that is avoided in the African American community (Mayo, 2004). Negative attitudes, perceptions, and racial biases that are common among this population continue to exist and are barriers to obtaining counseling services.

Religion and spirituality help many African Americans draw strength to overcome various forms of adversity, such as poverty, illness, rejection, prejudice, and racism (Ennis, Ennis, Durodoye, Ennis-Cole, & Bolden, 2004). In addition, the African American church is an open system that responds to the changing needs of its community (Ennis et al., 2004). The church provides political, economic, and social networks that allow members to effectively cope with life's changing pressures (Ennis et al., 2004). African American women's strong foundation in spirituality promotes a tendency to lean not on their own understanding but to look toward God. These women walk in a "Godfidence" knowing that God will work all things together for their good.

The African American community's perception of mental health treatment is shaped by their background experiences, religion, faith, and spirituality (Mattis et al., 2007). Some African Americans believe that they can seek therapy from their pastor instead of talking to a therapist whom they consider a stranger.

Psychosocial Factors

Often, African American women who prescribe to the SBWA internalize stress in an effort to maintain self-reliance and not seek social support from others (Watson-Singleton, 2017). These women often don't seek assistance from others because of the lack of social support due to the

conscious pressure to remain strong. The lack of social support contributes to extreme stress impact on their physical and psychological well-being (Kennedy, 2017; Watson-Singleton, 2017)

African Americans are often more prone to experience psychological stress in comparisons to white Americans (Barnes,2017). African American women who subscribe to the SBWA experience mental health problems to include reporting higher levels of sadness, hopelessness, worthlessness in an effort to take care of everyone health and neglecting their own health (Barnes,2017). Often, the African American women don't prioritize their self-care and seek self-nourishment, social support, and psychological help because this approach of seeking assistance could be perceived as a weakness (Barnes,2017; Kennedy, 2017). In the model, the psychosocial factors consist of (a) stress factors, (b) coping factors and (c) social support factors. These factors can be mediating variables that may have a positive or negative effect on depression in African women.

Stress Factors. Various psychological, individual behavior and cultural factors may influence how individuals perceive and respond to environmental stimuli (Cohen & Williamson, 1991). These factors may play a major role in the presentation or treatment of almost every general medical condition (e.g., depression, physical or other mental health problems). Stress has been found to be associated with higher rates of somatic and psychiatric illnesses (Cohen & Williamson, 1991). This image of SBWA increases the African American women's vulnerability to depressive symptoms associated with stress (Donovan & West, 2015). Stress and depression have been negatively correlated with self-esteem and happiness (Donovan & West, 2014).

Racism may be perceived as a stressor in the environment of African American women (Giurgescu et al. 2015; Kennedy, 2009a; Kennedy, 2009b; Kennedy, 2015; Kennedy, Mathis, & Woods, 2007). African American women are more at risk for depression than their white counterparts for experiencing stress and negative outcomes in areas such as health (Kennedy, 2009a). The effects of this oppression may include a seriously distorted view of self and others, feelings of hopelessness, and over-reliance on maladaptive strategies to include isolation (Jones, 2003). African women experience multiple complex problems because they contended with the stressful issues of gender, race, and class in society (Kennedy, 2009a). They experience stress because of discrimination both within and outside the communities. They may experience racism from other women, as well as men. The combined influence of gender and race broadly impacts the personal development of black women (Brown & McNair 1995; Kennedy, 2009a).

The research reported that African Americans who endorsed the SBWA are naturally strong, resilient self-contained, and self-sacrificing. Also, African American women who subscribed strongly to the SBWA have significantly higher reports of depression symptoms than those who only mildly embrace the SBWA (Donovan & West, 2015). The research reported the SBWA is associated with poorer psychological outcomes for African American women. These women have a high level of stress. Typically, they don't seek professional psychological treatment or have an unfavorable attitude for seeking professional psychological treatment.

Coping Factors. Coping is defined as those abilities that enable an individual to buffer the negative effects of stress or psychosocial vulnerability (Folkman & Lazarus, 1980). General coping responses refer to strategies that are usually used to deal with stressful events (Folkman & Lazarus, 1980). Coping mechanisms operate by either eliminating the source of the stress (e.g., solving a pressuring problem) or decreasing the unpleasant effect of stress (e.g., talking about feelings with a friend, family, spiritual leader, overeating, etc. (Kennedy, 2009a). For most African Americans, cultural plays a major part in their coping skills. Often, African American women

maintaining their image of being strong can be a deleterious effect on their coping behavior (Watson, & Hunter, 2015).

Depression is a stigma in the African American community (Kennedy, 2009a). African American women often feel guilty and don't want their families to see them as weak (Kennedy, 2009a).

Numerous psychological responses may follow perceptions of racism such as depression, stress, fears, distrust, paranoia, anger, etc. (Clark, Anderson, Clark, & Williams, 1999). Some African American women may grow up in a household with high levels of depression and inadequate coping mechanisms. However, the coping mechanisms of African American women are based on cultural practices. The lack of positive coping skills in African American women has contributed to depression and negative attitudes and behavior (Kubrin, Wadsworth, & DiPietro, 2006).

Today, African American women continue to use the SBWA characteristics as a mean of coping with race and gender inequalities (Woods-Giscombé & Black, 2010). The role of strength is learned and internalized as an expectable form of cultural coping passed down from generation to generation. African Americans rely on cultural coping styles in response to stress such as reliance on the extended family and community, religious belief, and spirituality. The research reported that African American women who internalize the SBW engage in high effort coping, avoidant coping, postponement of self-care and other maladaptive health behaviors and experience premature health deterioration. African American women are less likely to seek help for professional help for abuse, mental health and physical illnesses in comparison to other racial groups (Woods-Giscombé & Black, 2010). African Americans women who subscribed to SBWA have culturally influence coping patterns such as adherence to (a) longstanding culture of silence; (b) reliance on informal systems of support; and (c) placing the needs of others above their own.

Race-related stress events of African American women can contribute to depression (Woods-Giscombe, 2010). However, cultural coping may act as a buffer that protects women from negative psychological race-related stress.

Social Support Factors. Social support is the amount of psychological assistance a person perceived is available from people such as family friends, colleagues, and spiritual advisors (Cohen & Wills, 1985; Folkman & Lazarus, 1985; Kennedy, 2009b). African American women who subscribed to the SBWA usually believe that being dependent on others for support places her at risk for being hurt or manipulated (Woods-Giscombe, 2010) and this self-protective strategy prevent them from mistreatment, disrespect, and pain (Beauboeuf-Lafontant, 2009). Because of their fear of asking and accepting help have left the notion that their survival or success have been left to them.

Psychological well-being of African Americans is enhanced by a satisfactory marriage and threatened by an unsatisfactory marriage (Mitchell & Herring, 2003). African Americans experience greater strains and more unhappy marriages than White Americans (Mitchell & Herring, 2003). Lower levels of spousal support and financial satisfaction among African Americans make a significant contribution to these racial differences. Among African Americans who were legally married or in long-term common-law marriages; the marital strain is associated with higher levels of depression (Keith & Norword, 1997). Other social support systems for African American females are family and religious leaders. Also, African American women seek their healing through other women with similar experience (Mitchell & Herring, 2003).

Historically, the African American church has serviced as: (1) a social center; (2) a source of social therapy and social support; (3) and a form of social control. Religious faith has helped

African Americans cope with racism (Feagin & Sikes, 1994). African Americans have deep-rooted beliefs in spirituality and religion and use it as a way of understanding themselves and the meaning of their lives. Religion and religious institutions of African Americans have had a profound impact on individuals and broader African American communities (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000).

Spirituality has been reported to lower levels of depression, psychological stress, improve self-esteem, increase high life satisfaction, and lower levels of levels of alcohol and substance use/abuse, and risk-taking behaviors (Ellison, Trinitapoli, Anderson, & Johnson, 2007). Religious congregations serve as sources of formal and informal support for members (Ellison, Trinitapoli, Anderson, & Johnson, 2007).

African Americans are reluctant to seek mental health counseling services and have been reactive to sociopolitical events in the United States (Dana, 2002). As a result of the reluctant to seek treatment, African Americans tend to underutilize mental health services (Farris, 2004). They tend to seek help through their social networks which include the Black church and African American pastors (Farris, 2006).

In summary, health professionals working with African American women need to be aware of the biopsychosocial-spiritual factors contributing to depression in African American women. (Kennedy, 2009a; Kennedy, 2009b; Kennedy, 2010; Kennedy, 2015; Kennedy, Mathis, & Woods, 2007). Therefore, a holistic perspective is needed to be considered when providing treatment to this group. The next section will include suggested strategies for improvement.

Strategies for Improvement

In the model, the proposed strategies to improve treatment for the African Americans women are (a) developing and using more practical, reliable and valid scales for measuring depression; (b) assessing adequately for depression in African American women (e.g., using culturally sensitive tools) for gathering data and obtaining histories and physicals (H&Ps); (c) providing culture sensitive treatment; and (d) educating health providers on culturally competent treatment and care.

Often, African Americans are often misdiagnosed and under-treated in the conventional healthcare system (Sohail et al., 2014). A holistic approach is useful for African Americans in reducing depression (Sohail et al., 2014). This approach encompasses the biopsychospiritual aspects of their treatment.

Developing Culture Sensitive Tools/Practical, Reliable and Valid Scales for Depression

Depression in African American women is often under-recognized and undertreated among this population (NAMI, 2018). This increased risk for depression due to deleterious historical, socio-cultural, environmental and economic factors in their lives. In addition, depression among African American women may present with co-morbidities that include post-traumatic stress disorder, substance abuse disorders, and generalized anxiety (Carrington, 2006). Health providers need to use more relatable tools.

Researchers need to develop more reliable, practical, and valid tools to measure depression in African American and other minority groups (Kennedy, 2009a; Zasuzniewski et al., 2002). Tools for assessing depression need to be culturally sensitive. Focus groups are an excellent means of gathering data to develop tools. Also, health professionals providing care for African American women need to share their experiences with others in the most effective treatment regimen in treating this population. In addition, health professionals need to be aware of cultural factors when conducting an assessment and obtaining a medical history and physical (H&P).

Assessing for Depression in African American Women

Health providers working with African Americans need to frequently assess African American women for depression (Kennedy, 2009a). A cultural assessment would be a useful tool in data gathering. Often, it is difficult to treat mental health problems in African American women. Health providers often are less likely to detect diagnosable mental disorders in African American women (Miranda & Cooper 2004). The complexity of their treatment issues has had a negative impact on health outcomes. One reason is that African American women tend to minimize the serious nature of their problems. A second reason is that many believe their problem is just the blues and they are not proactive in changing their condition. A third reason is there is a stigma placed on mental health problems in the African American culture that they are a sign of weakness, not a sickness. They often feel they can take care of the problem on their own (Mitchell & Herring, 2003). In addition, African Americans often delay or will not seek treatment for depression (Black, 2003).

Clinical depression is often a vague disorder for African American women (Kennedy, 2015; Warren, 1995). White women report more “typical symptoms” of depression such as e.g., depressed mood while African American women report more somatic symptoms of depression. When African American women accessed the healthcare system, they are assessed for the physical symptoms and may not be assessed for depression. The origins of their symptoms are not explored. These women continue to complain of being tired, weary, empty, lonely, and sad. African-Americans share a strong history of self-reliance and resiliency that may correlate with denial of mental health problems (Holden et al., 2012). Shame and denial of mental health issues have also been identified as barriers to African Americans’ care-seeking behaviors.

Primary care physicians are less likely to detect signs of depression in African American women (Kennedy, 2015). However, primary care is in a key position to assess depression of African American women. They could have a significant impact on minority patients’ overall access to mental health care because of adequate assessment for depression and appropriate referrals.

Depression often has been misdiagnosed in the African American community (Carrington, 2006; Coridan & O’Connell, 2002). African Americans are less likely than Caucasians to receive appropriate care for depression (Bailey, Blackman, & Steven, 2009).

Some African American women may deny or not identify their depressed moods but report a variety of somatic complaints (NIMA, 2018). These somatic complaints may include gastrointestinal distress, chronic or intermittent pain, irritability, palpitation, dizziness, appetite change, lack of energy, change in sex drive, or sleep disturbance. Women often focus on somatic symptoms because they are more socially acceptable than the feeling of sadness, inability to concentrate, or loss of pleasure in usual activities.

Culture-bound symptoms of depression in African Americans must be acknowledged and incorporated into assessment and treatment. Non-traditional symptoms of depression in African American women include: a) hypertension, b) “falling out”- a sudden collapse, followed by dizziness, and c) sleep paralysis (Sohail et al., 2014).

African Americans are more likely to be undiagnosed and to experience more severe or persistent depression. African Americans and Hispanics are less likely to receive antidepressants. Women are more likely to be diagnosed with depression than men.

African Americans aged 15 to 24 years are more likely to report physical health problems than emotional instability (Bailey et al., 2009). African American women may access inpatient and outpatients with health problems, which may be related to undiagnosed depression. However,

primary care health services organizations are more culturally acceptable places to seek health care for African Americans than mental health organizations.

Often, African American women may be misdiagnosed because they go to health care visits looking well-groomed regardless of feeling depressed or sad. As a result, health professionals often see their appearance as well-groomed, not disheveled during their assessment. When assessing African American females, they often deny feeling depressed because they don't want to be seen as weak or not spiritually strong. In the African American culture, common phrases of African American women when referring to their health problems are "I am not going to claim it" or "I 'm bless." Historically, mental health professionals have consistently underdiagnosed depression disorders and over-diagnosed disorders like schizophrenia in the African American community.

Providing Culturally Sensitive Treatment

African Americans are less likely to seek treatment because of misconceptions about depression, stigma, and limited access to culturally relevant care (Rovner et al., 2014). Among ethnic minorities, some of the formidable barriers to seeking treatment include stigma surrounding mental illnesses, misperceptions of mental disorders as a sign of weakness or mental instability, and the limited health insurance coverage for mental health care (Holden et al., 2012).

Often, African Americans seek help from family, friends, neighbors, and religious leaders (Sohail et al., 2014). Religion and spirituality of African American cannot be ignored in the treatment of African Americans' lives (Sohail et al., 2014). For example; prayer is a common response for African American when in distress.

Current treatments for depression include psychotherapy, somatic or physical therapies and medications (Das & Weissman, 2006). African American women need to understand that depression is not a weakness, but a condition often resulting from a combination of causes (Warren, 1995). Antidepressants are useful for treating chemical imbalances or physical disorders. Psychotherapy is effective for depression (Kennedy, 2009a; Kennedy, 2010). However, certain surgeries or certain heart conditions, hormonal, blood pressure, or kidney medications may actually induce the symptoms of depression. African American women may require being more sensitive to certain antidepressants and smaller dosages than traditional treatment advise (McGrath, Keita, Strickland & Russo, 1990). African American women are often more sensitive to certain antidepressants requiring smaller dosages.

Psychotherapies and Pharmacologic Treatments

Psychosocial and pharmacologic treatments may be considered (Pajer, 1995). Psychosocial therapies should address issues that particularly affect women, such as competing roles and conflicts. Commonly used treatments include psychotherapy to correct interpersonal conflicts and to help women develop interpersonal skills; cognitive-behavioral therapy to correct negative thinking and associated behavior; and couples' therapy to reduce marital conflicts. In persons with mild to moderate depression, psychosocial therapies may be used alone for a limited period, or they may be used in conjunction with antidepressant medication (McGrath, Keita, Strickland & Russo, 1990).

Minority, patients (e.g., African American and Latinos) have poorer access to care and utilization of mental health services than Caucasians (Lesser et al., 2010). They are less likely to be prescribed and fill the prescription for a new antidepressant and less likely to receive non-pharmacological treatment compared to Caucasians. Therefore, disparities exist in treatment outcomes.

Depression can be treated successfully by antidepressant medications in (65%) of cases (Young, Klap, Sherbourne, & Well, 2001). The success rate of treatment increases to (85%) when

alternative or adjunctive medications are used or psychotherapy is combined with medications. However, some African Americans are reluctant in using psychiatric medications because of cultural beliefs.

In some cases, psychotherapy and drug treatment work much better for low-income young minority women than referrals to community health services (Young et al., 2001). Medications have been effective for poor and minority women if they are given support to overcome barriers to care. When used properly, medications appear to give better result than psychotherapies in some cases (Young et al., 2001). However, effective treatment for minority women had been questioned because depression treatment guidelines are based largely on white or college-educated patients. These limitations in research studies left a gap in the knowledge of treating low-income and minority women (Leven, 2003). Psychotherapies and medications have reported improving depression in minority women (Miranda et al. 2003).

Psychotherapies. Psychotherapy alone helps some depressed persons, especially those with mild to moderate symptoms (Kennedy, 2009a; Kennedy, 2010). Cognitive psychotherapy was found to be equally effective or more effective than pharmacotherapy. Reduction in depression symptoms after 12 sessions of cognitive therapy for African Americans was more effective in comparison to analytically oriented therapy sessions with similar duration. An approach to overcome distress and depression is through confronting the problem instead of avoiding the problem (Sohail et al., 2014).

The focus of individual or group psychotherapy is to enhance their self-esteem, and develop alternative strategies in order to handle their stress and conflicting roles appropriately (Kennedy, 2015; Warren, 1995). African American women should learn relaxation techniques, and develop alternative coping and crisis strategies. Group sessions may be more supportive for some women and may facilitate the development of wider selections of lifestyle choice and changes. Self-help groups may provide social support for depressed African American women to enhance the work accomplished in therapeutic settings. African American women need to monitor their on-going emotional and physical health as they progress in life (Warren, 1995).

African American women need to understand that depression is not a weakness, but a condition often resulting from a combination of causes (Kennedy, 2009a). Often, when African American women seek counseling, she is admitting she is not handling her problem well (Black, 2003). In addition, she is admitting she has a problem and validating lack of self-control. African American women may feel they are giving up power and may not want to be vulnerable when acknowledging feeling depressed (Black, 2003).

Psychotherapies should address issues of competing roles, lack of opportunities, lack of skilled, managerial jobs and low paying wages, etc. (Kennedy, 2009a; Kennedy, 2010). The focus of psychotherapies needs to address such issues as correcting conflict, correcting interpersonal conflict and developing interpersonal skills. Interpersonal and Social Rhythm therapy aims to help people manage their moods by analyzing and working with their circadian and social rhythms to manage stressful life events (Haynes, Gengler, & Kelly, 2016). This therapy may be effective in helping African American women manage their depressive symptoms and prevent future depressive episodes. Couple therapy needs to be used to reduce relationship conflict. In addition, psychotherapy or group therapy needs to focus on identifying the cause of depression, the treatment of choice, enhancing self-esteem, and developing alternative strategies in order to handle their stress and conflicting roles appropriately (Kennedy, 2009a; Kennedy, 2010). African American women need to learn relaxation techniques, and develop alternative coping and crisis strategies. Group sessions are excellent forums for African American women because of the

support and the wider selections of lifestyle choice and changes. Self-help groups may provide social support for depressed African American women to enhance the work accomplished in therapeutic settings (Warren, 1995).

Cognitive therapy focuses on removing symptoms by identifying and correcting negative behavior (Kennedy, 2009a; Kennedy, 2010). Therapists need to assist African American women in identifying and exploring more positive alternative strategies in problem-solving.

Pharmacologic Treatments. African Americans are less likely to receive appropriate treatment for depression and anxiety based on the guidelines for evidence from clinical trials (Young et al., 2001; Wang, Berglund & Kessler, 2000). Also, African Americans are less likely than White Americans to receive an antidepressant when their depression was first diagnosed in comparison to White Americans (27% versus 44%) (Blazer, Hybel, Simonsick, & Hanlon, 2000).

African Americans were less likely to receive newer selective serotonin reuptake inhibitor (SSRI) medications than White African Americans (Blazer et al., 2000). Serotonin reuptake inhibitor (SSRI) is antidepressants with fewer side effects than the older antidepressants which may increase compliance of medications because they tend to be easily tolerated. African Americans metabolize psychiatric medications much slower in comparison to whites. However, African Americans are prescribed higher dosages than Whites Americans resulting in severe side effect. Therefore, they are more prone to stop taking medications at a greater rate in comparison to whites.

African Americans are less likely than White Americans to receive antidepressants (27% versus 44%) at the early onset of the diagnosis for depression (Bailey et al., 2009). Also, African Americans are less likely to receive the antidepressants of selective serotonin reuptake inhibitors (SSRIs) (Bailey et al., 2009). African Americans may avoid or discontinue antidepressant because of poor tolerance of certain classes of antidepressants (Bailey et al., 2009). In addition, African Americans tend to respond more to antipsychotic medication and tricyclic antidepressants due to a difference in drug metabolism in the cytochrome enzyme of CYP2D6 with the hepatic cytochrome p450 2D6 microenzyme system playing a major role in this process (Bailey et al., 2009).

African Americans metabolize some antidepressants and antipsychotic medication at a slower rate than White Americans. Also, African Americans are more sensitive than White Americans to receive these medications resulting in more side effects (Bradford, Gaedigk, & Leede: 1998; Rudorfer & Robins, 1982; Ziegler & Biggs, 1977 a, b). Often, health providers prescribed higher dosages of medication to African Americans (Walkup et al., 2000). However, African American women are less likely to take antidepressant medications when prescribed (Miranda & Cooper, 2004).

Approximately (47% to 70%) of African Americans and Asians reported a slower metabolism of antidepressants (Bailey et al., 2009). Antidepressants with lower p450 such as SSRIs and selective norepinephrine uptakes may reduce the toxicity, side effects, and overdose for ethnic minority groups (Bailey et al., 2009).

Recent research clinical trial study revealed poorer antidepressant treatment response among black compared with white participants (Murphy et al., 2013). This racial disparity existed even after socioeconomic and baseline clinical factors drive the racial difference in antidepressant response were taken into account. Genetic ancestry rather than self-reported race explained the significant fraction residual difference. Results of findings reported the need for a larger sample of African American patients to identify the specific genetic mechanism.

Communication. Cultural differences play an integral role in the communication process. African Americans and their white counterparts tend to assign different meanings to the verbal and nonverbal mode of communication (Gudykunst & Hammer, 1987). These differences may promote miscommunication in their interactions. Whites tend to disclose more personal information than African Americans in their initial contact (Gudykunst & Hammer, 1987). African Americans are less likely to use self-disclosure in compromising conflict in a relationship in comparison to European Americans (Duncan, 1998).

Typically, the African American women mask their vulnerability and emotionality, preserve through her challenges, resist oppression, maintain power and control, and independently handle her own problems (Davis, 2016). The communication style of African American women is displayed by avoiding sensitive or feeling-oriented message topics, communicating direct, forthright, and sometimes blunt messages (Davis, 2016). African American women communicate by encouraging honesty and authenticity in others, sharing unsolicited opinions, and advise what other should do, presenting themselves with authority, confidence, power, and assuredness (Davis, 2016).

African Americans women use verbal and non-verbal communication techniques in their interactions (Davis, 2016). In some situations, African American women may alter their communication to reach a particular goal that coincides with their strength ideal to protect herself from potential harm from others such as asserting themselves firmly in conversations. They may send messages that their strength will not be compromised in the face of oppression. The message of strength can include the code-switching because this technique assists African American women to successfully maneuver a discriminatory society. They can avoid an emotional expression by palpating tense situations with a creative and playful message (Davis, 2016).

This communication approach of African American women is similar to the traditional communication of masculinity (Davis, 2016). In the United States, women and men are discouraged to displays characteristics of the opposite gender (Davis, 2016). Thereby, this communication style of African American women may not be socially acceptable in diverse environments.

The language may differ between African Americans and their therapist. African Americans do not readily communicate feelings or intentions in an open exchange (Ho, 1987). Also, African American family may have its own method of communicating with its members (McFadden, 1983).

The African American family member may vary in their gestures, dialect, tone, and tempo to communicate with others (Hines & Boyd-Franklin, 1982). The therapist needs to be culturally diverse of different communication styles to include the use of gestures and nonverbal cues. The communication patterns of many African American families are described as “paraverbal” communicating effect through pitch, tempo, and intensity of verbal messages or “quasi-verbal communication,” when the meaning is different from the words that are spoken (Hines & Boyd-Franklin, 1982).

Distrust of European American Therapists. However, the literature suggests that some African American clients prefer African American therapists (Neighbors, et al., 1992; Snowden & Hu, 1996). For example, McNair (1992) indicate that African Americans with a high level of mistrust tend to prefer African American counselors over European American counselors. It has been suggested that African American clients fear a disclosure in front of European American therapists, a phenomenon often called “healthy cultural paranoia.”

Research indicates that African American clients fear having to face a lack of understanding and receptiveness of European American therapist in dealing with racial myths and misunderstandings (Gregory & Leslie, 1996). Often, African Americans preferred to have African American practitioners. In some cases, the lack of choice in practitioner may have some effect on their compliance with health care.

Religion or Spirituality

For some, clergies and counselors, spirituality may be an approach for persons with depression (Kennedy, 2015). Often, African Americans seek counseling from their clergies. As mentioned, African Americans churches vary in their level of preparation in dealing with mental health problems. The need to refer church members to mental health professionals becomes extremely important in smaller congregations. Coping strategies among African Americans seems to revolve around the importance of religion and spirituality (Sheu & Sedlacek, 2004).

Spirituality needs to be considered in the treatment of African American women (Kennedy, 2009a; Kennedy, 2015). For many African American women, spirituality is necessary for the concept of healing for depression. Spirituality creates attitudes that embrace *hope* and *empowerment*. In a healthy person, spirituality is critical for overall mental health using the network found in the family, neighborhood, church, mosque, temple, and community (Mitchell & Herring, 2003). The African American church provides frequent prayer, reading religious material, reading scriptures, and health education (Ellison, Trinitapoli, Anderson, & Johnson, 2007). Spirituality has been reported to lower levels of depression, psychological stress; improve self-esteem, increase high life satisfaction, and lower levels of alcohol and substance use/abuse and risk-taking behaviors (Ellison et al., 2007). Religious congregations serve as sources of formal and informal support for members (Ellison et al., 2007).

Education of African American Women on Depression. The education of African American women on depression is crucial (Kennedy, 2009a). African Americans women must put forth an effort to be successful by overcoming fears. They must recognize the symptoms of depression. No two people experience mental problems in the same way. Symptoms may vary in severity and duration among different people. For example, a feeling of worthless is a common sign of depression in white women and change of appetite is a common symptom of depression in black women. As mentioned, African American women have numerous medical problems, in addition to a higher incidence of depression (Bender, 2005). African American women with these health problems may be unaware of common health problems co-exist with depression. Common health problems in African American women associated with depression are cardiovascular, hypertension, HIV, stroke, diabetes, cancer, Parkinson's disease, thyroid problems, multiple sclerosis, and obesity (NIMH, 2018). The intensity and frequency of depression are highest in the more severely ill clients. Often, these depressive symptoms are unrecognized and thus are untreated by health professionals (NMHA, 2018). Therefore, it is important for health providers to provide education on depression for African American women with health problems. Health professionals need to take into consideration the SBWA when treating this group.

Involving the Community in Support

Community Support Systems. Organizations in the African American community e.g. church groups, schools, health departments, community centers, sororities, etc. need to provide more support and resources for African American women (Kennedy, 2009a). For example, support groups are excellent forums for African American women to deal with psychosocial issues. African American women seek their healing through other women with similar experiences.

Also, African American women seek mental health services far less frequent as white women (Das & Weissman, 2006; Kennedy, 2015; Miranda & Cooper, 2004). Also, they often engage in informal sources of help, such as prayer or having “sister support group” and talk with friends in the hope of gaining what others may gain in individual therapy. Independent support for black women is being created around the country. Also, in supportive settings such as support groups, church affiliation groups (e.g., women ministries), available resources etc. need to be provided to assist with mental health services, financial support, etc. African American women tend to rely on these groups rather than mental health services (Kennedy, 2015). They tend to use networks such as friends, family, churches etc., to help them cope. The involvement of organizations in their communities may be helpful in identifying depression, access to the appropriate health services, and treatment of African American women for depression. These strategies are particularly helpful because when they seek mental health care it is usually later in life or when the condition is in the late stage.

Culturally Sensitive Education for Health Providers

Health professionals who especially provide care to African American population need to take the lead in educating the public on healthcare issues of African American population e.g., health disparities, treatment, consultation, etc. (Kennedy, 2017). There is a need for more conferences, workshops, etc. focusing on assessing culturally competent care of African Americans and other minority groups.

Holistic treatments have been beneficial and the influence of religion has proven to be quite effective (Sohail et al., 2014). A holistic approach of confronting troubles instead of avoiding them is a popular approach. This approach is encouraged by family, friends, neighbors and religious leaders in the African American community. Taking into consideration the SBWA is necessary when educating others about this group. This approach is valuable information for health professionals and researchers assisting scholars in understanding the biopsychosocial-spiritual aspects impacting their overall health outcomes.

Education of Health Professionals. Health professionals need to be educated on identifying common symptoms of depression in African American women (Kennedy, 2009a). Their cultural barriers may be influenced by language and values in the relationship between health providers and clients. Some women may deny or not identify their depressed moods but report a variety of somatic complaints e.g., gastrointestinal distress, chronic or intermittent pain, irritability, palpitation, dizziness, appetite change, lack of energy, change in sex drive, or sleep disturbance. They often focus on these symptoms because they are more socially acceptable than the feeling of sadness, inability to concentrate, or loss of pleasure in usual activities.

Education on Communication. Health professionals need to know the language of African Americans (Kennedy, 2009a; Kennedy, 2015). Less than (10%) of African Americans suffering from depression seek help (Black, 2003). Cultural barriers, including in the presentation of symptoms may influence language and behavior mannerisms (Barbee, 1992).

African American world-views are concerned with family and group survival in American society. Communicating to African American women with health professionals need to be culturally sensitive (Kennedy, 2017). Scarinic, Beech, and Watson (2004) examined the relationship between physicians-interaction and depression among African American women. Depression was positively associated with difficulty talking with physicians, likelihood of discussing problems with physicians, and reporting physician had made offensive comments. In addition, they were more likely to change physicians due to dissatisfaction. In addition, researchers and clinicians have observed that minorities tend to prematurely terminate treatment

more often than their White counterparts (Bischoff & Sprenkle, 1993; Kennedy, 2017; Kurilla, 1998; Murphy et al., 2010; Neighbors, et al., 1992).

Consequences

Improved Health Outcomes

In summary, The *Multifaceted Model of African American Women and Depression* is a useful model with a holistic perspective in developing culturally sensitive treatment and research on African American women. This model includes biopsychosocial-spiritual components including many factors contributing to the development of depression in African American female (Kennedy, 2009a; Kennedy, 2009b; Kennedy, Mathis & Woods, 2007). The disparities in the mental health of African American women are based on numerous factors as follows: (a) environmental factors, (b) socioeconomic factors (SES), (c) health factors, and (d) cultural factors. In this model, the psychosocial factors influencing positive or negative outcomes of African American women with depression are (a) stress factors, (b) coping factors, and (c) social support factors (Kennedy, 2009a; Kennedy, Mathis, & Woods, 2007).

In the model, *intervening conditions* are based on strategies for improvement consisting of the need to include the *Faith-Based Community* because spirituality is very important in their treatment. Therefore, this proposed model is useful for health professionals when providing culture-specific treatment. The *Strong Black Women Archetype* needs to be considered when planning mental health strategies for African American women. A holistic approach needs to be taken into consideration these factors in this model to improve the *health outcomes* of the African American woman.

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