**Mental Healthcare Seeking Behavior in African-Americans**

By

Kimberly W. Bennett

A Master's Paper submitted to the faculty of
the University of North Carolina at Chapel Hill
In partial fulfillment of the requirements for
the degree of Masters in Public Health in
the Public Health Leadership Program.

Chapel Hill

2006

Advisor

Second Reader

7/14/06
Date

**Abstract**

Mental health plays a vital role in how we function daily. The overall prevalence of mental illness in the United States is estimated at 21%.[1] Unfortunately, people who suffer from mental illness do not always receive needed treatment. Disparities in mental healthcare are rampant and contribute to the large number of African Americans who are not treated for their mental illnesses. Differences in mental healthcare utilization between blacks and whites may play an important role in sustaining mental healthcare disparities. This paper addresses the magnitude of the problem by exploring if there is a difference in utilization of mental healthcare between African Americans and whites and further, factors that may influence potential differences in utilization.

## I. BACKGROUND/INTRO/FOCUSED QUESTION

### *Introduction*

Mental health is a fundamental part of our lives and plays an intricate part in how we function in day to day life. The medical community's understanding of mental illness and its treatment has evolved enormously over recent decades. Yet there remains a vast amount of unknown information. Many Americans suffer from some form of mental illness with the overall prevalence in the United States estimated at 21%.[1]

Disparities in mental health status, service utilization, treatment, and experience of care are as prominent as with other medical disorders.[2] However, unlike the widespread attention that disparities in physical illness in the United States have received from governmental and private agencies, mental health disparities are to a large extent ignored.

Among the factors that maintain mental health and healthcare disparities, mental healthcare utilization may play a prominent role. In order to adequately explore this, however, we need to understand not only differences in utilization between racial groups but the factors that influence these differences. I will review the literature to define the magnitude of the problem and further attempt to define the major factors that influence differences in healthcare seeking behaviors between African-Americans and whites.

### *Mental Health Disparities*

When thinking about health disparities, many people think about disparities in prevalence of illnesses. In the case of mental illnesses, some studies

suggest that the prevalence among racial and ethnic minorities is similar to that of whites. The Epidemiologic Catchment Area (ECA) surveys, for example, showed that after adjusting for socioeconomic and demographic differences, there is no difference in rates of lifetime and current mental disorders between African Americans and whites.[3] The National Comorbidity Survey, however, found that African Americans had a lower lifetime prevalence of mental illness than whites[4]. Though these epidemiological studies indicate that compared to whites, African Americans do not have greater rates of mental illness, the results must be interpreted with caution. Most of the results, which rely on household data, may fail to capture the disproportionate number of African-Americans who are incarcerated, institutionalized, homeless or living in inner-city and rural areas. The absence of these data suggests that the prevalence of African-Americans suffering from mental illness may be higher than these studies indicate.[1]

In 1999, David Satcher, former U.S. Surgeon General, created the Surgeon General's Report on Mental Health.[5] This report highlights scientific advances responsible for promoting our understanding of mental illness and its treatment. Findings from a 2001 supplement to the original report emphasize disparities that extend beyond differences only in prevalence of mental illnesses. Four major areas of disparities involving minorities are mentioned. Specifically, minorities (1) have less access to and availability of mental health services, (2) are less likely to receive recommended mental health services, (3) when they do receive treatment, are more likely to receive a poorer quality of mental healthcare, and (4) are underrepresented in mental health research.

The Surgeon General's report also mentioned barriers to mental healthcare that are common to all Americans, including cost, fragmentation and lack of availability of services, and social stigma associated with mental illness.[5] Barriers unique to minority groups include racism and discrimination, fear and distrust of the medical community, and differences in language and communication. Though all of these are important factors, barriers to care has not been systematically studied.

The literature has highlighted differences in patterns of care received by African Americans and whites. For example, African Americans are more likely to discontinue treatment prematurely than whites.[6] African-Americans suffering from depression and anxiety are less likely than whites to receive care consistent with official practice guidelines.[7] Elderly African-Americans are considerably less likely to receive antidepressant medications than their White counterparts.[8] Among Medicare enrollees in Medicare health plans, African-Americans appear less likely than whites to receive follow-up visits after psychiatric hospitalization, not consistent with a Health Plan Employer Data and Information Set guideline.[9] There are many reasons for these disparities, including low socioeconomic status, lack of education, and lack of research and knowledge relating to minorities. Providers' personal biases may also be one of these barriers.

***Health Service Utilization: Differences in Help-Seeking***

Underutilization of services accounts for a large component of the disparities in mental healthcare. There is no consensus on the magnitude of this problem, however, or on the factors that contribute to it. Barriers more described

in minorities include cultural misunderstandings and provider bias.[10] These barriers can undermine trust, further preventing minorities from seeking treatment which continues to perpetuate the disparity.

There have been dozens of studies that have attempted to characterize the differences in mental healthcare service use between African-Americans and whites. Although some of the factors affecting service utilization or decisions to seek mental health services are experienced by the entire population, there are others that are unique to African-Americans. It may be that ethnic differences in utilization account for some of the mental healthcare disparities. It is important that we characterize and understand these differences because the lack of consensus on this issue contributes to our inability to effectively address these disparities.

Healthcare services utilization can be influenced by both individual and societal determinants. It is helpful to think of the components of healthcare utilization using the framework created by Andersen and Newman called "The Framework for Viewing Health Services Utilization".[11] This framework suggests that societal determinants and the health services system work to influence individual determinants, which further influence health services utilization. This review will be focused on the individual determinants that influence utilization.

***Focused Question***

The purpose of this systematic review is to assess whether there is a substantial difference in healthcare utilization between African-Americans and whites. Should such a difference exist, it would warrant more attention from the

public health community. I will also begin to explore factors unique to African-Americans that may affect utilization of mental healthcare services. To date there has been no critical review of the literature that looks at these issues.

There are two questions that I hope to answer with this review. First, are African-Americans less likely to utilize mental healthcare services than white populations? Healthcare utilization includes seeking professional services from either specialty mental healthcare specialists or non-mental healthcare specialists. Mental health specialists would include psychiatrists and psychologists. Non-mental healthcare specialists would include general medicine doctors like those practicing in family medicine, general medicine, and pediatrics. Secondly, what major factors could be uniquely associated with a potential difference in mental healthcare seeking behavior between African-Americans and whites?

By understanding the influences that affect mental healthcare seeking behavior in this community, we can better focus our efforts to increase the number of African Americans seeking treatment and further help to alleviate the disparities in mental health. The information gained from this review has major implications for being able to adequately create appropriate interventions and better shaping those that already exist.

## II. METHODS

### *Literature Search*

I searched MEDLINE and Psychinfo to identify articles relevant to the issue of mental healthcare utilization by African Americans. I used either Medical Subject Headings (MeSH or MH) as search terms when available or key

words when appropriate. In both databases, I used a combination of the terms "help seeking", "health care seeking", "mental health", "black", and "African American". I limited my electronic searches to "human" and "English language"; I searched sources from January 1900 to June 2006. Because there is not a lot of literature on this topic, I kept the subject headings and publication dates broad to ensure that I would get an adequate number of articles. I supplemented the electronic search by hand searching bibliographies.

I used the National Library of Medicine publication type tags to identify systematic reviews, randomized controlled trials, and observational studies. Once again, because of the paucity of the literature on my subject, I did not want to limit the types of articles that would be included in my review. All citations were imported into the electronic database Refworks.

***Study Selection***

I reviewed the titles and abstracts of the articles that resulted from my literature searches and excluded those that did not meet the eligibility criteria (Figure 1). I then obtained the full text of the remaining articles. Abstracts and articles were considered for exclusion if they did not meet pre-established criteria with respect to the study design, duration, patient population, interventions, and outcomes (Table 1).

Outcome measures and eligibility criteria for the review are shown in Table 1. Because my second question is to define those factors that may predict greater or lesser utilization in African-Americans, I wanted to focus on those factors unique to African-Americans. The population studied was limited to the

adult black population in the United States. Studies were excluded if they looked at black populations in other countries. The black population is a heterogeneous population that includes not only African-Americans, but people from various ethnic backgrounds who may be classified as black. The comparison group for this population was whites from the United States.

The types of studies (e.g. randomized controlled trials, cross-sectional studies, etc.) reviewed were not limited. Studies of any duration and number of study participants were eligible for inclusion. To reduce the chances of publication bias, I searched for both published and unpublished studies, including data from abstracts.

***Data Abstraction***

I used a structured data abstraction form to ensure consistency in the assessment of the studies. Each study was assigned a quality rating using the following abstracted data: study question and design, source population, study population, comparability of groups, attrition rate, measurements, selection bias, measurement bias, confounding, method of analysis, and results.

***Quality Assessment***

I assessed the internal validity, or quality, of the studies based on predefined criteria that were developed by the US Preventive Services Task Force and the National Health Service Centre for Reviews and Dissemination. I served as the sole reviewer who assigned all the quality ratings. Elements of internal validity assessment included randomized and allocation concealment, selection and measurement biases, and confounding. Validity was rated as either good,

fair, or poor. Trials that had a fatal flaw in one or more categories were rated as poor and were not included in the analysis. Trials that met all criteria were rated as good quality. External validity, or generalizability, was also assessed and reported but did not influence quality ratings.

## III. RESULTS

### *Mental Healthcare Utilization*

Thirteen studies met the eligibility criteria (Figure 1). Table 2 lists the studies, sample sizes, populations, tools for measuring help-seeking, factors associated with help-seeking by African Americans and whites, and the quality rating. Table 3 contains the results regarding utilization. Twelve studies explored differences in mental healthcare seeking behavior between African-Americans and whites. Four studies explored factors that might explain differences in mental healthcare utilization between African-Americans and whites.

Alegria and colleagues used respondents from the National Comorbidity Survey conducted from 1990-1992[12]. The purpose of this study was to compare estimated rates of use of specialty care between ethnic and racial groups, adjusting for psychiatric disorder, insurance status, and socioeconomic status. They assessed use of outpatient mental health services among a total of 987 African-Americans and 6026 non-Latino whites by asking respondents if they had spoken to a professional about symptoms or disorders in the 12-month period before the interview. When the sample was restricted to those who reported psychiatric disorders, there was no significant difference between groups in the overall use of any mental health, general health, or human services. However, a

significantly higher number of non-Latino whites reported receiving specialty care (11.8%) than did African Americans (7.2%). Also, when controlling for demographics, insurance status, wealth, income, zone of residence, geographic location, psychiatric illness, and disability, African Americans were less likely than non-Latino whites to use mental health services with an odds ratio of 0.45 (95%CI: 0.26-0.77).

Alvidrez looked at ethnic patterns in mental health service use and factors that might explain those patterns among 63 African-American and 38 European-American women in a women's clinic at a large, urban, public care hospital.[13] Exposure to the mental health care system was measured by asking respondents if they had ever gone to a doctor or mental health professional for a personal or emotional problem. More whites (58%) than did African-Americans (36%) reported past mental health visits. Blacks were 0.37 times as likely as whites to make a mental health visit and 0.56 times as likely when controlling for self-reported drug problem, probable alcohol problem, mental health visits by friends/family, balance-related beliefs, and religious/supernatural beliefs.

Ayalon and Young evaluated racial group differences in help-seeking behaviors in a community college sample of 70 black and 66 white community college students.[14] They assessed help-seeking behaviors by asking "How frequently have you used each of the following services: psychologist/school counselor/social worker, social worker, psychiatrist, clergy, ER, medical doctor, alternative medicine, religious service in the past year?" Blacks used religious services significantly more frequently (87.1% of blacks, 74.2%of whites, $p<0.01$)

and used psychological or social services significantly less (34.3% for blacks, 53.0% for whites, $p<0.01$) after controlling for overall level of psychological distress and physiological distress. Blacks were just as likely as whites to use psychiatric services (24.3% for blacks, 24.2% for whites).

Broman looked at whether racial differences existed in seeking help from any source and from specific professional sources.[15] He also looked at whether problem type and psychological distress contributed to racial differences in professional help seeking. Data were used from two different surveys, the National Survey of Black Americans (NSBA) and the Americans View Their Mental Health restudy (AVTMH). The NSBA produced 673 black respondents and the AVTMH produced 751 white respondents. Professional help-seeking was measured by asking respondents if they had ever talked over a crisis with anyone. Then they were given a list of professional sources (i.e. medical, mental health, clergy, and "other") and asked if they had ever talked with any of them. The proportion of white and black respondents seeking help from any professional were 0.418 and 0.451; from a mental health professional, 0.081 and 0.126 ($p<0.05$); from a medical professional, 0.237 and 0.097 ($p<0.05$); from clergy, 0.121 and 0.088 ($p<0.05$); and from other sources, 0.129 and 0.177 ($p<0.05$), respectively.

Sociodemographic factors played a minimal role in the racial differences in professional help-seeking in the Broman study.[15] At the lowest levels of distress, controlling for sociodemographic factors, blacks were significantly more likely than whites to seek help from any professional source. The likelihood of

seeking any professional help was similar at higher distress levels, at 0.746 ($p<0.05$) for white respondents and 0.914 for black respondents. However the likelihoods of blacks and whites seeking help from mental health professions were 0.549 ($p<0.05$) and 0.421 ($p<0.05$); from medical professionals, 1.79 ($p<0.05$) and 2.76 ($p<0.05$); and from other sources, 0.553 ($p<0.05$) and 0.697, respectively.

Cooper-Patrick and colleagues used data from the Baltimore site of the National Institute of Mental Health's (NIMH) Epidemiologic Catchment Area (ECA) survey to look at 590 African-Americans and 1072 whites to compare their mental health services utilization during the 1980s and 1990s.[16] This was the only prospective observational study found in the literature. Mental health service utilization was measured by inquiring about talking to any health professional about an emotional, nervous, drug, or alcohol problem within the 6 months preceding the interview. Services were divided into specialty mental health and general medicine services, and respondents were asked from where and from whom they had received mental healthcare. The odds of receiving any mental health services for African Americans as compared with whites, differed significantly different between baseline and follow-up ($p=0.012$). At baseline, African Americans were ~40% less likely than whites to receive any mental health services, with an odds ratio of 0.62 (95%CI: 0.42-0.94). At follow-up, there was no difference in the reported use of any mental health services between African Americans and whites, with an odds ratio of 1.04 (95%CI: 0.76-1.41). However, adjusted odds for receiving specialty mental health services were lower

for African Americans than for whites, with a baseline odds ratio of 0.76 (95%CI: 0.41-1.43) and a ratio at follow-up of 0.65 (95%CI: 0.27-5.25).

Diala and colleagues used data from the National Comorbidity Survey (NCS) to explore racial differences in attitudes towards seeking professional care, and their association with the use of mental health services.[17] The study looked at 680 African-Americans and 4479 whites who had not suffered a major depressive episode and 63 African-Americans and 441 whites who had suffered a major depressive episode. Use of mental health services was measured by visits to a psychologist or psychiatrist during the 12 months prior to data collection. In the group who had reported no major depressive episode, African Americans were 0.3 (95%CI: 0.2-0.7, $p<0.001$) times as likely as whites to use mental health services. In those who reported a major depressive episode, African Americans were half as likely as whites to use services with an odds ratio of 0.4 (95%CI: 0.2-0.9, $p=0.048$).

Dupree and colleagues looked at 510 African-Americans and 216 Caucasians in 40 faith-based, health, community, and senior settings in Hillsborough County, FL, to determine whether underutilization of mental health services reflected beliefs and attitudes or some other unknown variable.[18] These variables were measured using a 47-item survey that inquired about willingness to accept care, preferred mental health intervention, preferred professional treatment provider, and preferred treatment location. African Americans were more likely than Caucasians to consult with clergy, their family doctor or a nurse, obtain advice from a family member, and attend a lecture on life management, and they

were less likely to manage feelings in isolation. Caucasians were more likely to seek help within a professional's office, use medication to manage problems, or deal with them in isolation. African Americans preferred a faith-based resource, were more likely to select a church office location, and were 2.5 times more likely to select a member of the clergy for help. They were less than 1/3 times as likely as Caucasians to select a psychiatrist and significantly less likely to choose a psychologist. They were also less likely to prefer mental health treatment in a professional's private office or choose a community mental health center.

Husaini and colleagues examined the relationship between psychiatric symptoms and utilization of both formal and informal resources by an elderly population in Nashville.[19] Data on 600 black individuals were used from interviews conducted in 1987 and on 600 white individuals from interviews conducted in 1989. Help-seeking behavior was assessed by asking subjects what they typically did or whom they turned to for help when they were really upset, had serious worries, or had nervous, personal, or emotional problems. Responses were classified into three categories: help from professionals, help from support network, and self-help responses. Very few respondents (<6% in each sample) indicated that they consulted a psychiatrist or psychologist, a social worker, or a counselor for their emotional problems. One-fourth to 1/3 of the elderly sought help from their family physicians (30.8% among blacks and 28.5% among whites). No racial differences existed in seeking help from either family physicians or mental health professionals for emotional problems.

Kimerling and Baumrind used the 2001 California Women's Health Survey to examine disparities in access to specialty mental health services as it relates to utilization in an effort to better understand racially linked barriers to access to mental health services.[20] They examined perceived need among 82 African-Americans and 629 Caucasians, examined 31 African-Americans and 419 Caucasians who sought services, and looked at 28 African-Americans and 380 Caucasians who used services. Perceived need was assessed by asking respondents if they had wanted mental health services in the previous 12 months. Seeking services was assessed by asking the women who had a perceived need, whether they had actually tried to seek services in the previous 12 months. Utilization was measured by asking women who had tried to seek services, whether they had actually obtained the mental health services they reported wanting in the previous 12 months. All odds ratios were adjusted for race/ethnicity, age, education, presence of frequent mental distress, income below the federal poverty level, and health insurance status. Among Caucasian women, 66.6% of those who had perceived a need for mental health services in the previous year sought services, but only 37.8% of African-American women with perceived need sought services. However, 90.6% of Caucasian women and 90.3% of African-American women who sought services obtained them. African-American women were 0.3 (95%CI: 0.2-0.5, $p<0.01$) times as likely as white women to seek specialty mental health services when they believed they needed them. Among women who sought services, African-American women were 1.1 (95%CI: 0.3-3.6) times as likely as white women to obtain these services.

Lasser and colleagues looked at respondents to the 1997 National Ambulatory Medical Care Survey (NAMCS) and the 1997 National Hospital Ambulatory Medical Care Survey (NHAMCS) to explore similarities between racial inequalities in outpatient mental health care in the 1980s and the late 1990s.[21] Blacks had fewer visits than whites (per 1000 population per year) to psychiatry (psychiatrist or psychiatry subspecialty) (37.8 vs. 106.0, $p<0.0001$), fewer visits to primary care with psychiatry complaints as a reason for the visit (39.7 vs. 58.4, $p<0.05$), and fewer visits to psychiatry plus visits to primary care with a psychiatric complaint as a reason for the visit (77.5 vs. 164.0, $p<0.0001$).

Minorities received markedly fewer mental health services during visits to a primary care office.[21] Blacks had substantially lower rates than whites of receipt of mental health counseling, antidepressant prescriptions, and antianxiety prescriptions. Blacks also made significantly fewer visits for talk therapy than whites ($p<0.01$). Finally, blacks had substantially lower rates of receipt of drug therapy (73.7) than did whites (109.0, $p<0.01$).

During visits to psychiatrists, blacks received significantly less talk therapy from psychiatrists than did whites, with visit rates of 33.6 per 1000 population for blacks and 85.1 per 1000 population for whites ($p<0.0001$).[21] The largest difference observed was in visits for psychotherapy, with whites making 3 times as many visits (per 1000 population) as nonwhites. Nonwhite patients also had significantly fewer visits for psychoactive drug therapy than did whites.

Snowden compared African Americans' and whites' use of outpatient mental health services among the respondents from the Epidemiologic Catchment

Area Study (ECA).[22] She looked at a total of 4300 African-Americans and 12,152 whites from the community, 1373 African-Americans and 504 whites from jails and prisons, and 251 African-Americans and 459 whites from mental hospitals. This population was surveyed across the five sites including Baltimore, St. Louis, North Carolina, New Haven, and Los Angeles. Use of outpatient mental health services was measured by asking respondents if they had ever gone to outpatient programs or providers of healthcare (physician, emergency room) or mental health services (private and publicly practicing therapists and mental health centers) with "emotions, nerves, or mental health." Among respondents from the community, without controlling for any other factors, African Americans were 0.37 (3.8% vs. 10.4%, $p<0.01$) times as likely as whites to have received care from a private therapist, 0.75 times as likely to have received care from a physician (11.5% vs. 13.7%, $p<0.01$), and 0.84 times as likely to have received care from a mental health center (2.4% vs. 3.2%, $p<0.01$). African Americans were more likely to have received services from the emergency room ($p<0.01$) and were less likely to have received services from a public therapist, although this difference was not significant.

After controlling for age, sex, and racial characteristics, African Americans were 0.33 ($p<0.01$) times as likely to receive care from a private practice therapist, 0.65 ($p<0.01$) times as likely to receive care from a public clinic therapist, 0.57 times as likely to receive care from a mental health center (difference was not statistically significant), 0.70 ($p<0.01$) times as likely to receive care from a physician, and 0.67 ($p<0.01$) times as likely to receive care

from the emergency room[22]. Combining respondents from the community and institutions, and controlling for the factors mentioned above, African-Americans were 0.70 ($p<0.01$) times as likely to receive services from a private practice therapist, 0.80 ($p<0.01$) times as likely to receive care from a public therapist, 0.80 ($p<0.01$) times as likely to receive care from a mental health center, 0.97 (difference not statistically significant) times as likely to receive care from a physician, and 0.97 (difference not statistically significant) times as likely to receive care from the emergency room.

Sussman and colleagues looked at respondents from the St. Louis Epidemiologic Catchment Area (ECA) survey to explore the relationships between treatment-seeking for a major depressive episode and the characteristics of respondents and symptoms in order to determine those groups least likely to seek care.[23] The goal was to examine the data collected on attitudes and beliefs in an attempt to uncover possible factors contributing to or mechanisms underlying this relationship.

Treatment-seeking was measured by asking respondents if they had spoken to a professional about emotional or psychological problems in the past 6 months as an outpatient or in the past year as an inpatient, or if they at some time had told a doctor or professional about symptoms of depression.[23] Blacks with a major depressive episode were significantly less likely than whites to have spoken to any professional (including social worker, clergy, alternative healer) about mental health or emotional problems in the 6 months prior to the interview (black 49.3%, white 74.3%, $p<0.05$). Blacks with a major depressive episode were also

significantly less likely to have ever told a doctor or professional about the symptoms of depression (black 47.3%, white 71.0%, $p<0.05$).

Groups did not differ by age, sex, number of years of education, prestige score based on occupation, or health insurance coverage.[23] The only demographic variable that differed was marital status: fewer blacks reported being married or living as though married (33% vs. 50%, $p<0.05$). The illness characteristics of the two groups of depressives also did not differ significantly.

***Factors Affecting Utilization***

Alvidrez looked at ethnic differences in cultural variables by asking female respondents about family attitudes, stigmatization, and beliefs about causes of mental illness.[13] Latinas and African-Americans reported higher levels of agreement than European Americans with the statement that problems should not be talked about outside of the family, and this difference was statistically significant. European Americans disagreed more with the statements that mental illness is stigmatizing than African Americans. African Americans rated items in the religious/supernatural category as more important than European Americans. European Americans gave higher ratings of importance to balance factors, or a belief that an imbalance in self or environment causes mental illness, than did African Americans. Examples of balance factors include lack of harmony with nature or people, lack of rest, quality of diet, and the weather.

Ayalon and Young attempted to explain racial group differences by assessing the roles of health locus of control beliefs and symptom attribution.[24] Locus of control was measured using scales that assessed beliefs about God's

control and the control of self, powerful others, and fate. Symptom attribution was measured by asking respondents the extent to which they attributed 13 common somatic symptoms to either psychological attributes (i.e. emotional distress), somatizing attributes (i.e. somatic illness), or normalizing attributes (i.e. external transitory environmental events). Belief in the power of God and normalizing symptom attributions were found to mediate differences between blacks and whites in religious help-seeking behavior. However, none of the variables mediated group differences in psychological or social help-seeking behaviors.

Cooper-Patrick and colleagues conducted focus groups to gather the view points of individuals to explore attitudes that influenced patient help-seeking behavior and specific aspects of treatment that influenced patient preferences for management of depression.[25] Comments from three focus groups comprising professionals, black patients, and white patients were used. Eight hundred and six distinct comments were identified and grouped into 16 broad categories or aspects of help-seeking activities and treatment. Black patients made more comments than white patients on the impact of spirituality (9.9% vs. 3.0, $p<0.01$) and stigma (7.6% vs. 1.5%, $p<0.01$) on their help-seeking behavior and preferences for treatment. White patients made more comments than black patients on the various attributes of each type of treatment (41.9% vs. 22.0%, $p<0.001$) and the relation between physical health and depression (7.6% vs. 3.2%, $p<0.05$). Blacks discussed using church and church members for support more frequently than whites; they felt seeking care was not culturally acceptable among family

members and peers. In the black patient focus group, cultural mistrust and concerns about being used as a "guinea pig" for medical experimentation were also raised. The lack of availability of mental health professionals belonging to one's gender, race, and religious background was a concern expressed more often by black patients.

Sussman attempted to identify factors associated with treatment seeking.[23] Among blacks, variables significantly related to treatment-seeking were age, the number of symptoms in the worst episode of depression, the number of episodes experienced, and the duration of the longest episode. Those at highest risk of not seeking care were the young (<35 years of age), those with few symptoms in a single episode, those who had experienced fewer episodes in their lifetimes, and those without long episodes. The severity of the problem also appeared to play a part in determining whether treatment was sought. Among whites, no variables were significantly related to treatment-seeking. Many of the measurements of severity likely related to age. The greatest differences between blacks and whites were found among those with the least severe problems.

Among blacks, the only aspect of social functioning significantly related to treatment-seeking was disturbed relationships with friends and relatives ($p<0.05$).[23] Among whites, those who felt needed by others tended to seek care more frequently than those who felt unneeded or unwanted ($p<0.001$). Also, whites may more readily recognize the presence of symptoms or problems in ways more akin to psychiatrists, or the "medical" paradigm, than do blacks. There was no evidence to suggest that being depressed was more stigmatizing for

blacks than for whites. Blacks cited fear of being hospitalized as the primary reason for not seeking care significantly more often than whites (14.1% compared to 0.4%, $p<0.05$). Significantly more blacks also reported that lack of time and fear of treatment had entered into their decision ($p<0.05$).

## IV. DISCUSSION

### *Summary of Mental Healthcare Utilization and Associated Factors*

All of the studies reviewed found differences in the utilization of mental health services between blacks and whites. However, these studies had mixed findings in regards to whether blacks or whites had a higher or lower rate of utilization of mental healthcare services. Ten of 12 studies found that blacks used mental health services less than whites on at least one measure of healthcare utilization. Two of 12 studies found that blacks were just as likely as or more likely than whites to use mental healthcare services. Overall, from our results, we can conclude that blacks do have lower utilization rates of mental healthcare services compared to whites.

Although there were not a significant number of studies reviewed for evidence on factors that may explain differences in utilization, the four studies that were reviewed do suggest factors that may explain this difference and that should be further explored. Findings highlight differences between blacks and whites on issues about mental illness with illness being less culturally acceptable and more stigmatized among blacks compared to whites. Differences in beliefs about causes of mental illness were also mentioned. Spirituality and the church

seemed to be more of a factor in African-Americans than in whites when deciding whether or not to seek professional help for mental health problems.

***General Discussion***

According to the literature reviewed, African-Americans are less likely than whites to utilize mental healthcare services. The majority of studies reviewed found this to be true in at least one of their measurements of mental healthcare utilization. Factors that seem to be uniquely associated with a decreased likelihood of mental healthcare seeking behavior in African-Americans versus whites includes culture, religion, family attitudes, stigmatization, and beliefs about the causes of illnesses.

These conclusions are further supported by literature not included in this review. In regards to the factors that may influence utilization of services, there were several studies that did not meet the selection criteria for this review, yet still may shed some light on factors related to utilization. Although one study found evidence that African Americans were less likely than whites to receive help for mental health problems from family, friends, and religious sources[26], several other studies found that African Americans used informal sources of help more than formal sources.[27-29] Thus, although African-Americans may not be seeking professional help, they may recognize that help is needed and seek it from other sources.

Positive or negative attitudes may be one of the biggest factors that determine whether African-Americans seek mental healthcare or not. The literature has shown mixed results in terms of if blacks having more positive or

negative attitudes towards mental healthcare. Diala and his colleagues conducted a study to determine whether African Americans have more negative attitudes towards seeking mental health services than do Whites using respondents from the National Comorbidity Survey.[30] They found that both among the general population and among those with depression, African-Americans reported more positive attitudes towards seeking healthcare than their white counterparts. For example, African-Americans were 1.5 (95%CI: 1.3-1.8) times more likely than those in the general population and 1.8 (95%CI: 1.1-3.1) times more likely among those with major depression to seek professional help for emotional problems. African-Americans in the general population and those with major depression were just as likely as whites to be very comfortable in talking to a professional, with odds ratios of 1.2 (95%CI: 1.0-1.4) and 1.1 (95%CI: 0.9-1.3), respectively.

Gonzalez and colleagues also used the National Comorbidity Survey to examine possible differences in attitudes between blacks and whites towards mental healthcare.[31] They found that compared to whites, African-American respondents were up to twice as likely to have a positive attitude towards mental health treatment; they were 2.01 (95%CI: 1.28-3.16, $p<0.01$) times as likely to be willing to seek help and had a 2.07 (95%CI: 1.33-3.23) times higher comfort level in talking to a professional. Though both of these studies may indicate that African Americans have more positive attitudes towards seeking care, it is not clear of how attitudes leads to actual help seeking. However, attitudes should be considered as a factor when creating any type of intervention.

It is possible that some barriers are more of an issue for blacks than whites and these may prevent them from using mental healthcare services. Hines-Martin conducted a study in which she explored the experiences of help-seeking among African American males and females and identified barriers associated with seeking mental health services.[32] She identified barriers at three different levels including individual, environmental, and institutional. When looking at the vast amount of experiences by the participants, she found that the barriers most frequently reported were related to thoughts/knowledge deficit, beliefs/attitudes/values, and family/significant others/community. The thoughts/knowledge deficit included lack of awareness that the problem they were experiencing was a "mental health" problem and the assumption that their experiences were just a normal response to difficult life situations. Barriers in the beliefs/attitudes/values category included socioeconomic and political limitations. Barriers in the family/significant others/community category included individuals or groups that adversely affected help-seeking through their influence on the participant. Many of these African Americans sought religious advice and pastoral counseling to avoid mental health services.[32]

Thompson conducted focus groups to identify beliefs and values about psychotherapists, psychotherapy, and barriers to treatment.[33] Key barriers to service utilization included stigma, lack of knowledge, lack of affordability, lack of trust, impersonal services, and lack of cultural understanding. There are well documented differences in care based on race and ethnicity.[10] African-American patients' negative experiences with the healthcare system, mistrust, and perceived

discrimination can prevent them from seeking needed medical treatment .[34] These experiences may highlight culture as being both a vital part of and potential barrier to patients' decisions to seek professional or formal services.

One of the main limitations to these studies is that they only look at African-American populations and don't compare them to other populations. They do however give us an idea as to what factors may influence help seeking behavior and which of them may need to be explored further in comparative studies. Also, it is not clear if these factors are unique to this population. In order to get a more accurate assessment of this, comparative studies need to be carried out.

***Limitations***

The cross-sectional study was used by all of the articles reviewed to assess utilization and factors associated with utilization. Although randomized controlled trials are the gold standard, it would not be possible to carry out a randomized controlled trial or a cohort study to answer the question of how utilization differs between blacks and whites. It is also not possible to carry out these types of studies to examine the factors that may influence the differences in utilization. A cross-sectional study was the most appropriate way to access both of these questions. From this information, we are able to get a snapshot of the population who is utilizing these services and generate a hypothesis on how certain factors influence mental healthcare utilization in blacks.

Alternatively, there are many disadvantages that go along with conducting a cross-sectional study. In general, they are the best studies of prevalence.

Therefore, we can assess population trends in utilization of mental healthcare and attitudes and beliefs affecting utilization. Even though associations can be studied, causation and temporality can not be determined. For this reason, we can examine the factors that may be associated with decreased utilization, but we can not definitively say that the factors identified cause a decrease in utilization over a specific period of time.

Results of this review must be considered in the context of its limitations. Cross-sectional studies are subject to biases including selection bias, measurement bias, and confounding. There were clear examples of these in the studies reviewed. In many of the studies, the reasons that people decided not to participate in the surveys were not described, possibly creating a bias since people who decided to participate in the study might differ from those who decided not to participate. Further, most of these studies were secondary data analyses. Although they described how the original study populations were obtained, it was not always clear how participants were selected for the current analysis.

Two of the studies compared groups in which the participants were from two different surveys. This contributed to a decrease in the internal validity of these studies. Finally, in the majority of the studies, the data were self-reported, but participants may not have always remembered details with accuracy, creating the possibility of measurement bias. A more accurate measurement may involve getting information from health records. All of these studies are subject to confounding. These studies did not take into account all factors that may have

accounted for differences in utilization of services like the availability of services depending on location and socioeconomic status.

One of the main advantages of these studies is that many included very large samples, and therefore, power to detect a difference was not an issue. The variation in measures used by many of these studies, however, made it difficult to compare them, therefore making collective interpretation of the results a challenge. Some studies differentiated between seeking mental health services from a mental health specialist and seeking services from a general medical doctor, while others did not make this distinction. Further, the studies did not use the same time period for services sought prior to the survey. For example, some asked about services sought in the previous 6 months, while others asked about services sought during the previous 12 months. Finally, the study populations differed; some surveys looked at the college population, some looked at the elderly while, and others looked at a representative sample of the entire population.

***Public Health Implications***

Disparities in utilization of services may have devastating effects on mental health and quality of life for many Americans. This issue warrants the attention of the public health community, focusing on factors highlighted in the literature such as culture and religious beliefs.

Encouraging cultural competence may be an important step in adequately addressing culture as being one of the factors identified as affecting mental healthcare utilization in blacks. Additionally, it may also be a way of addressing

deficiencies in our healthcare system. In her review of culturally competent healthcare systems, Anderson defines cultural competency.[34] She defines culture as "an integrated pattern of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups".[34] Competence can be defined as "having the capacity to function effectively as an individual and organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities".[34] The Health Resources and Service Administration (HRSA) defines cultural competency as "a set of congruent behaviors, attitudes, policies and procedures that come together in a system, agency, or among professionals which enable the system agency or those professionals to work effectively and efficiently in cross-cultural and diverse linguistic situations on a continuous basis".[35] These definitions should serve as the core of how our healthcare system should approach addressing disparities.

A person's culture influences how they define health and illness. Further, it also influences how symptoms are recognized, interpreted, and to what they are attributed. All of these may determine when help is sought and what source the help will come from. A clinician who understands how culture influences the presentation of symptoms of mental illness and how it influences mental health seeking behavior may be better able to empathize with members of this population. A more comprehensive understanding of cultural ideas would also dispel negative stereotypes that may shape the behavior of clinicians during a clinical encounter.

Cultural competency has implications not only for healthcare providers, but for our healthcare system as a whole. Both the medical and public health communities should be equipped to ensure the provision of appropriate services no matter what their cultural beliefs. Although published evidence of the effectiveness of culturally competent mental health services is limited, this may be a means through which healthcare disparities can be reduced.[34]

An additional factor identified in this review seems to highlight religion as a fundamental issue that may have some bearing on how African Americans approach mental illness. Religion and spirituality play a fundamental role in the lives of many African-Americans. For example, African Americans have been thought to partake in more religious activities than the general population.[36]

The church serves many purposes in the lives of African-Americans. It is a place where they can congregate and express their religious and spiritual beliefs and values, and where they can deal with adversity, preserve family patterns and units, and get involved in social issues that affect African-Americans. Overall, the church serves as a vital source of social support.[36]

Some studies have shown a positive correlation between religious involvement and various indexes of well-being such as life satisfaction and happiness. Others have found that participation in religious activities such as church attendance, positive attributions for life events, and intrinsic religious motivation were positively associated with fewer depressive symptoms and less suicidal behavior.[36] Being that religion, spirituality, and the church is such a focal point in the African-American community, it may be more likely that this

population may relies more on this informal source for seeking help with mental issues. The church may also be a vessel through which other factors can be targeted like generating more dialogue about mental health issues, attempting to dispel stigma associated with mental illness, and regaining cultural trust.

***Implications for Future Research***

The evidence reviewed here supports the notion that a disparity in mental healthcare utilization exists. In the future, it may be helpful to compare characteristics of African Americans who use mental health services and those who do not. Studies should also look at factors that differentiate between white and African-American non-users of mental health services. By identifying these factors, they can be more appropriately targeted by public health efforts.

Further research is needed to more efficiently target public health resources. Intervening with more informal resources for mental healthcare may help to target public health interventions in order to get more African-Americans to seek treatment for mental illness. For example, one study found that parishioners who attended churches with mental health ministries had more favorable attitudes, greater perceptions of support from friends, pastors, church, and greater intentions to seek professional mental health services than parishioners who attended churches without mental health ministries[37].

More effective partnerships need to be formed between the medical and public health communities and religious establishments. This may be achieved with community-based participatory research. Community-based participatory research differs from conventional research by striving to create more of a

working relationship with the community as opposed to presenting the community with a plan of action that they were not involved with. This is a way through which lasting partnerships can be formed in which both the public health and medical community and the African-American community can benefit.

**FIGURE 1 – Search Strategy**

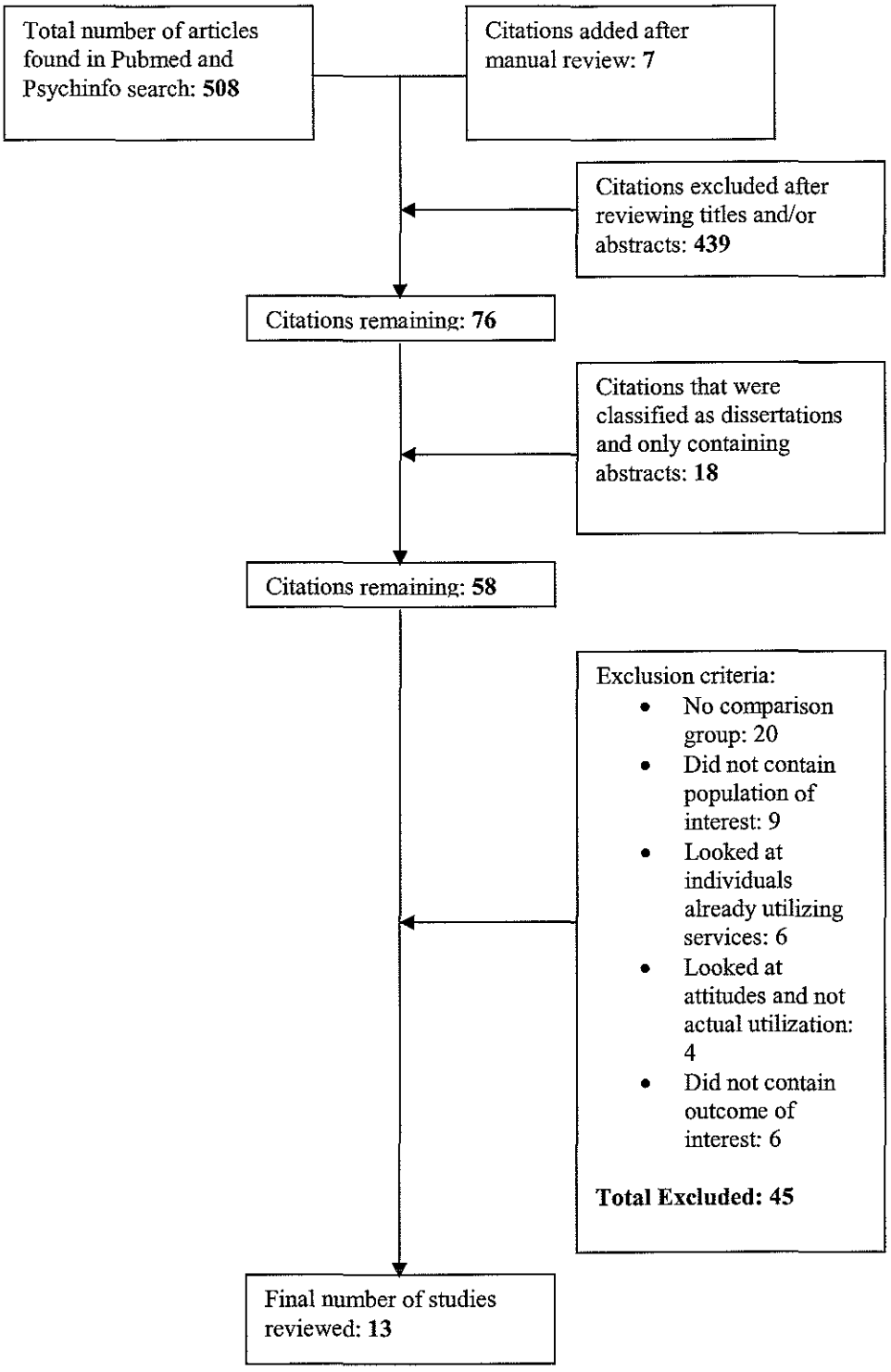

**TABLE 1 – Outcome Measures and Study Eligibility Criteria**

| Key Question, Outcomes of Interest, and Specific Measures | Study Eligibility Criteria |
|---|---|
| Key Question 1<br>• Mental healthcare utilization with any provider | Study Design<br>• Type of studies not limited<br>Minimum Duration of Study<br>• Study duration not limited<br>Study Population<br>• ≥18 years of age<br>• African-American population compared with White American<br>• Live in the United States<br>• Population could not be identified by a medical, non DSM-IV diagnosis |
| Key Question 2<br>• Factors associated with mental healthcare use in African-Americans<br>  • Shared with whites<br>  • Unique to African-Americans | Study Design<br>• Type of studies not limited<br>Minimum Duration of Study<br>• Study duration not limited<br>Study Population<br>• ≥18 years of age<br>• African-American population compared with White American<br>• Live in the United States<br>• Population could not be identified by a medical, non DSM-IV diagnosis |

**TABLE 2 – Studies on Utilization of Mental Healthcare Services**

| Source | Sample Size | Population | Tool Measuring Help-Seeking | Factors Measured | Quality Rating | |
|---|---|---|---|---|---|---|
| | | | | | Internal Validity | External Validity |
| Alegria et al., 2002 | 987 AA, 6026 non-Latino whites | National Comorbidity Survey (NCS) | Use of general and specialty care in previous 12 months | None | Good | Good |
| Alvidrez, 1999 | 63 AA, 38 European American | Respondents at a women's clinic at a large, urban, public hospital | Exposure to mental health system | Family Attitudes, Stigmatization, Beliefs About Causes of Mental Illness | Fair | Fair |
| Ayalon and Young, 2005 | 70 black, 66 whites | Community college students in a large Midwestern city | Use of psychologist/school counselor/social worker, social worker, psychiatrist, clergy, ER, medical doctor, alternative medicine, religious service in the past year | Locus of control and symptom attribution | Fair | Fair |
| Broman, 1987 | 673 blacks, 751 whites | National Survey of Black Americans (NSBA) and the Americans View Their Mental Health restudy (AVTMH) | Professional help-seeking | None | Fair | Good |

| Source | Sample Size | Population | Tool Measuring Help-Seeking | Factors Measured | Quality Rating | |
|---|---|---|---|---|---|---|
| | | | | | Internal Validity | External Validity |
| Cooper-Patrick et al., 1999 | 590 AA, 1072 whites | Baltimore site of the NIMH Epidemiologic Catchment Area (ECA) Survey | Inquiry about talking to any health professional about emotional, nervous, drug, or EtOH problem within 6 months | None | Good | Good |
| Cooper-Patrick et al., 1997 | 806 comments | Community professionals and patients | None | Spirituality, stigma, church, compatible mental health professional | Fair | Fair |
| Diala et al., 2000 | 743 AA, 4920 whites | National Comorbidity Survey (NCS) | Visits to psychologist or psychiatrist during previous 12 months | None | Fair | Good |
| Dupree et al., 2005 | 510 AA, 216 whites | Faith-based health community and senior setting | Talking to any health professional about emotional, nervous, drug, or EtOH problem | None | Fair | Fair |
| Husaini et al., 1994 | 600 AA, 600 whites | Elderly population in Nashville | Inquire about what they typically did or whom they turned to for help when upset, worried, or had nervous, personal, emotional problems | None | Fair | Fair |
| Kimerling et al., 2005 | 82 AA, 629 white | 2001 California Women's Health Survey | Obtained mental health services | None | Fair | Fair |
| Lasser et al., 2002 | 24,715 patient visits | 1997 NAMCS, 1997NHAMCS | Receipt of talk and drug therapy | None | Fair | Good |

| Source | Sample Size | Population | Tool Measuring Help-Seeking | Factors Measured | Quality Rating | |
|---|---|---|---|---|---|---|
| | | | | | Internal Validity | External Validity |
| Snowden, 1999 | 5924 AA, 13115 whites | Epidemiologic Catchment Area Survey (ECA) | Visits to outpatient programs and providers of healthcare and mental health services with emotions, nerves, or mental health | None | Good | Good |
| Sussman et al., 1987 | No information | St. Louis Epidemiologic Catchment Area Survey | Spoke to professional about emotional or psychological problems in past 6 months | Age, Number of symptoms, number of episodes, duration of longest episode, disturbed relationships, lack of time, fear of treatment | Fair | Good |

**TABLE 3 – Summary of the Results from Studies on Utilization of Mental Healthcare Services**

| Source | Mental Health Care Utilization | | | |
|---|---|---|---|---|
| | Black (%) | White (%) | Odds Ratio (CI) | P Value |
| Alegria et al., 2002 | 7.2 | 11.8 | 0.45 (0.26-0.77) | None |
| Alvidrez, 1999 | 36 | 58 | 0.37 (before adjustment)<br>0.56 (after adjustment) | None |
| Ayalon and Young, 2005 | Less | More | None | <0.01 |
| Broman, 1987 | 45.1<br>12.6<br>9.7 | 41.8<br>8.1<br>23.7 | None | None |
| Cooper-Patrick et al., 1999 | None | None | 0.62 (0.42-0.94)<br>1.04 (0.76-1.41)<br>0.76 (0.41-1.43)<br>0.65 (0.27-5.25) | None |
| Diala et al., 2000 | None | None | 0.3 (0.27-0.70)<br>0.4 (0.20-0.90) | <0.001<br>0.048 |
| Dupree et al., 2005 | AA < 1/3 likely to select a psychiatrist and significantly less likely to choose a psychologist | | None | None |
| Husaini et al., 1994 | 30.8 | 28.5 | None | None |
| Kimerling et al., 2005 | 37.8<br>90.3 | 66.6<br>90.6 | 0.3 (0.2-0.5)<br>1.1 (0.3-3.6) | <0.01<br>0.87 |
| Lasser et al., 2002 | 3.78<br>3.97<br>7.75 | 10.6<br>5.84<br>16.4 | None | <0.0001<br><0.05<br><0.0001 |
| Snowden, 1999 | 3.8<br>11.5<br>2.4 | 10.4<br>13.7<br>3.2 | 0.37 0.33 0.70<br>0.75 0.70 0.97<br>0.84 0.57 0.80 | <0.01 <0.01 <0.01<br><0.01 <0.01 NSS<br><0.01 NSS <0.01 |
| Sussman et al., 1987 | 49.3<br>47.3 | 74.3<br>71.0 | None | <0.05<br><0.05 |

## REFERENCES


1. Snowden LR. Barriers to effective mental health services for African Americans. *Mental Health Services Research*. 2001;3:181-187.

2. Dougherty RH, American College of Mental Health Administration. Reducing disparity in behavioral health services: A report from the american college of mental health administration. *Administration and Policy in Mental Health*. 2004;31:253-263.

3. Robins L., Regier D. *Psychiatric Disorders in America*. New York: The Free Press; 1991.

4. Kessler RC, McGonagle KA, Zhao S, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the united states: results from the national comorbidity survey. *Archives of General Psychiatry*. 1994;51:8-19.

5. Mental health: Culture, race and ethnicity - a supplement to mental health: A report of the surgeon general. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; 2001.

6. Sue S, Zane N, Young K. Research on psychotherapy with culturally diverse populations. In: Bergin AE, Garfield SL, eds. *Handbook of Psychotherapy and Behavior Change (4th Ed.)*. John Wiley & Sons; 1994:783-817.

7. Young AS, Klap R, Sherbourne CD, Wells KB. The quality of care for depressive and anxiety disorders in the united states. *Archives of General Psychiatry*. 2001;58:55-61.

8. Blazer DG, Hybels CF, Simonsick EM, Hanlon JT. Marked differences in antidepressant use by race in an elderly community sample: 1986-1996. *American Journal of Psychiatry*. 2000;157:1089-1094.

9. Schneider EC, Zaslavsky AM, Epstein AM. Racial disparities in the quality of care for enrollees in medicare managed care. *Journal of the American Medical Association*. 2002;287:1288-1294.

10. Snowden LR. Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health*. 2003;93:239-243.

11. Andersen R, Newman JF. Societal and individual determinants of medical care utilization in the united states. *Milbank Mem Fund Q Health Soc*. 1973;51:95-124.

12. Alegria M, Canino G, Rios R, et al. Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino whites. *PsychiatricServices*. 2002;53:1547-1555.

13. Alvidrez J. Ethnic variations in mental health attitudes and service use among low-income African American, Latina, and European American young women. *Community Mental Health Journal*. 1999;35:515-530.

14. Ayalon L, Young MA. Racial group differences in help-seeking behaviors. *Journal of Social Psychology*. 2005;145:391-403.

15. Broman CL. Race differences in professional help seeking. *American Journal of Community Psychology*. 1987;15:473-489.

16. Cooper-Patrick L, Gallo JJ, Powe NR, Steinwachs DM, Eaton WW, Ford DE. Mental health service utilization by african americans and whites: The baltimore epidemiologic catchment area follow-up. *Medical Care*. 1999;37:1034-1045.

17. Diala C, Muntaner C, Walrath C, Nickerson KJ, LaVeist TA, Leaf PJ. Racial differences in attitudes toward professional mental health care and in the use of services. *American Journal of Orthopsychiatry*. 2000;70:455-464.

18. Dupree LW, Watson MA, Schneider MG. Preferences for mental health care: A comparison of older African Americans and older Caucasians. *Journal of Applied Gerontology*. 2005;24:196-210.

19. Husaini BA, Moore ST, Cain VA. Psychiatric symptoms and help-seeking behavior among the elderly: An analysis of racial and gender differences. *Journal of Gerontological Social Work*. 1994;21:177-195.

20. Kimerling R, Baumrind N. Access to specialty mental health services among women in california. *Psychiatric Services*. 2005;56:729-734.

21. Lasser KE, Himmelstein DU, Woolhandler SJ, McCormick D, Bor DH. Do minorities in the united states receive fewer mental health services than whites? *International Journal of Health Services*. 2002;32:567-578.

22. Snowden LR. African American service use for mental health problems. *J Community Psychology*. 1999;27:303-313.

23. Sussman LK, Robins LN, Earls F. Treatment-seeking for depression by black and white americans. *Social Science & Medicine*. 1987;24:187-196.

24. Ayalon L, Young MA. Racial group differences in help-seeking behaviors. *Journal of Social Psychology*. 2005;145:391-403.

25. Cooper-Patrick L, Powe NR, Jenckes MW, Gonzales JJ, Levine DM, Ford DE. Identification of patient attitudes and preferences regarding treatment of depression. *Journal of General Internal Medicine*. 1997;12:431-438.

26. Snowden LR. Racial differences in informal help seeking for mental health problems. *Journal of Community Psychology*. 1998;26:429-438.

27. Alexander JR. The influence of acculturation of African-Americans on referral for psychotherapy and utilization of other help systems. *Dissertation Abstracts International Section A: Humanities and Social Sciences.* Univ Microfilms International; 2000;60:2675-2675.

28. Brown JA. African American church goers' attitudes toward treatment seeking from mental health and religious sources: The role of spirituality, cultural mistrust, and stigma toward mental illness. *Dissertation Abstracts International: Section B: The Sciences and Engineering.* Univ Microfilms International; 2004;65:2087-2087.

29. Watkins VC. African-American women and psychotherapy: Exploring behaviors, attitudes, beliefs, experiences, and needs. *Dissertation Abstracts International: Section B: The Sciences and Engineering.* Univ Microfilms International; 2000;61:2228-2228.

30. Diala CC, Muntaner C, Walrath C, Nickerson K, LaVeist T, Leaf P. Racial/ethnic differences in attitudes toward seeking professional mental health services. *American Journal of Public Health*. 2001;91:805-807.

31. Gonzales MD. Predictors of psychological distress and mental health help-seeking among black and white older adults. *Dissertation Abstracts International: Section B: The Sciences and Engineering.* Univ Microfilms International; 2003;64:1901-1901.

32. Hines-Martin V, Malone M, Kim S, Brown-Piper A. Barriers to mental health care access in an African American population. *Issues in Mental Health Nuring*. 2003;24:237-256.

33. Thompson VLS, Bazile A, Akbar M. African Aamericans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice*. 2004;35:19-26.

34. Anderson L, Scrimshaw S, Fullilove M, Fielding J, Normand J. Task force on community preventive services. Culturally competent healthcare systems: a systematic review. *American Journal of Preventive* Medicine. 2003;24:68-79.

35. Vega WA. Higher stakes ahead for cultural competence. *General Hospital Psychiatry*. 2005;27:446-450.

36. Constantine MG, Lewis EL, Conner LC, Sanchez D. Addressing spiritual and religious issues in counseling African Americans: Implications for counselor training and practice. *Counseling and Values*. 2000;45:28-38.

37. Clansy CD. The relationship between mental health ministries in the african-american church and professional mental health help-seeking. *Dissertation Abstracts International: Section B: The Sciences and Engineering.* Univ Microfilms International; 1998;59:0457-0457.