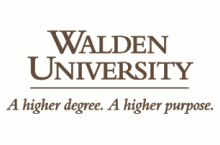

2020

Black Women's Voluntary Use of Mental Health Services

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This is to certify that the doctoral dissertation by

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Walden University
2020

Abstract

Black Women's Voluntary Use of Mental Health Services

by

Natasha N. Wright, LCSW

MS, Fordham University, 2015

BS, University of Bridgeport, 2012

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Service

Walden University

May 2020

Abstract

According to the American Psychiatric Association, Black women engage in formal mental health services at a lower rate than White men and women. In addition, the issues faced by Black women engaging in mental health services are multiplicative, major, and often divisive. Much of the research to date has centered on the barriers to, and negative experiences of, Black women in mental health. Grounded in critical race theory and Black womanist thought, this study investigated the lived experiences of Black women who voluntarily engaged in mental health services. The study included a purposive sample of 6 Black women from 2 urban communities in Connecticut who (a) identified as Black, (b) were 18 years of age or older, (c) had continuously and voluntarily used mental health services for at least 3 months, and (d) and had been discharged from mental health services. Colaizzi's phenomenological method was used to code and analyze the data. Five themes emerged: (a) engaging in mental health services is a last resort; (b) marriage, children, and work-related issues are reasons for seeking out mental health services; (c) overcoming stigma, stereotypes, and cultural myths is necessary for treatment; (d) finding the right fit in a provider is a challenge; (e) coping skills, empowerment, and self-efficacy are outcomes of engaging in mental health services. The results of this study may positively affect social change by directly affecting the work of psychologists, social workers, mental health professionals, doctors, and Black women who are ambivalent about seeking mental health services. Understanding the lived experience of seeking, engaging, and completing mental health treatment can be a catalyst for change among Black women.

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Dedication

This study is dedicated to Black women and girls everywhere; you deserve to be heard, healed, whole, and loved.

Acknowledgments

To my Lord and Savior: God who makes all things possible! To my sons, Mondre and Courtney, you both are the very beat of my heart. Your smiles motivate me to be better. The two of you are my reasons why. We were not created to journey through life alone. As we journey through life, if we are fortunate enough, we collect priceless treasures called friends that journey with us. To all my friends who have journeyed with me, thank you for your love and support. To Denise, a true friend indeed. Thank you! To Kesia and Teresa, my sister girlfriends, and my colleagues, I know for sure I would not have made it through this process without your support, encouragement and, laughs. Much appreciated. To my parents, Jimmy and Nancy Small, and my sisters, Jasmine and Jocelyn, thank you for all the cooked meals and free babysitting. To my prayer partners, your prayers have carried me through some of my darkest moments. You are my angels.

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Chapter 1: Introduction to the Study

Introduction

Mental illness exists among all races, cultures, and all socioeconomic statuses (U.S. Department of Health and Human Services, 2013). Mental illness is prevalent among Black women; nevertheless, few seek out mental health services (Copeland & Butler, 2017). The American Psychiatric Association (2017) reports Black women engage in formal mental health services at a lower rate than Whites, both men and women. According to Jones (2015), issues faced by Black women in mental health treatment are multiplicative, major, and often divisive. The author further noted that when Black women do seek out mental health services, it is typically after a crisis has occurred. Moreover, Black women are more likely to seek help from informal supports such as friends, family, and the church, as opposed to seeking professional support (Payne, 2008; National Alliance of Mental Illness, 2004). The purpose of this study was to examine the positive outcomes of Black women who voluntary use of mental health services.

In this chapter, I outline the study and cover the following topics: a summary of mental illness, including prevalence, among Black women, the research problem, the purpose of the study, the research question, the theoretical and conceptual framework, methodology, assumptions, scope of the problem, limitations, and significance.

Background

According to the 2014 U.S. Census Bureau report, 13.2% of the U. S. population, or roughly 45.7 million people, identify as Black or African American. Of these, 16%, or

roughly 6.8 million people, had a diagnosable mental illness in the past year (Mental Health America, 2018). Blacks use mental health services at about one-half the rate of Whites (Substance Abuse and Mental Health Services Administration, 2017).

The Black community, more specifically Black women, experience unique barriers to accessing and using mental health services. Various reasons, both social and cultural, are noted. According to the literature, they include historical biases, distrust of the medical system, poverty, insurance, stigma, unmet cultural needs, the ideal of the StrongBlackWoman, and gender as barriers for Black women wishing to seek mental health services (Copeland & Butler, 2007; Gibbs & Fuery, 1994; Jones & Sheftall, 2015; McNair, 1996; Neal & Turner, 1991; Roberta & Priscilla, 2007; Ward, Clark, & Heidrich, 2009).

Gibbs and Fuery (1994) noted that Black women experience two different perspectives. The first perspective is triply disadvantaged (gender, ethnicity, and poverty). Second, strong, resilient, and adaptive in their ability to cope with adversity, support their families and develop avenues of self-esteem and self-actualization (Gibbs & Fuery, 1994). Black women have overcome many barriers through developing a set of cultural attitudes, a pattern of coping strategies, and a series of help-seeking behaviors that have enabled them to survive and sometimes thrive (Gibbs & Fuery, 1994). These learned coping strategies have fed the underutilization of mental health treatment among Black women. Revenge, humor, and social networks comprised of other Black women are coping strategies employed by Black women who face adversity and mental health

conditions (Mattis, 2002). Black women believe that mental illness can be treated with counseling, yet are reluctant to get treatment (Ward et al., 2009).

At this time, the research on Black women and mental health treatment is incomplete. The current research contributes insight into the many barriers as to why Black women do not seek out, engage in, or discontinue mental health services prematurely. This study offers a counter-narrative. It provides insight from Black women who have successfully overcome barriers to access and utilization of mental health services in an effort to understand the contributing factors, narratives, and past experiences of Black women who successfully engaged in mental health services and overcame barriers to treatment. A study inclusive of Black women must be conducted. Therefore, using a qualitative study, I examined the lived experiences of Black women who reside in an urban setting and who have overcome the barriers to accessing and using mental health services voluntarily. In this study, I addressed a gap in the literature by focusing on positive outcomes of engaging in mental health services. I sought to add to the body of literature by adding a counter-narrative to the existing research on Black women and help-seeking behavior. The data provided in this study can assist community programs, mental health providers, and researchers to identify and address barriers to engaging Black women in mental health services.

Problem Statement

According to the U.S. Department of Health and Human Services Office of Minority Health (2017), African Americans and Blacks are 10% more likely to report having serious psychological distress than Non-Hispanic Whites. Roughly 18.6% of

Blacks have a mental health condition (National Association of Mental Illness [NAMI], 2018). Of the 18.6% of Blacks with mental health conditions, only 10.3% of Black *women* use mental health services (NAMI, 2018).

Between 2009 and 2011, 21.8% of Non-Hispanic White women received mental health treatment compared to 9.9% of Non-Hispanic Black women (U.S. Department of Health and Human Services Maternal and Child Health Bureau, 2013). In 2015, among adults ages 18-64 years old with a diagnosed mental illness, 48% of Non-Hispanic Whites received mental health services compared to 31% of Blacks (American Psychiatric Association, 2017). Moreover, when compared to Whites, Blacks use emergency rooms and primary care physicians rather than mental health specialists (American Psychiatric Association, 2017). Due to unmet cultural, ethnic and, gender needs, Black women often delay treatment or withdraw early (Jones & Sheftall, 2015). Thus, the low utilization rate of mental health services among all Blacks is a consequence of both access and use. Access to healthcare is concurrent with education, employment, and health insurance (Institute of Medicine, 2002), which are all also correlated with geography and race in the United States (National Research Council, 2004).

There are several noted reasons for this lower utilization rate. Black women, in general, see an increased incidence of mental health disorders, especially depression (Cardemil, Kim, Pinedo & Miller, 2005; Walton & Shepard-Payne, 2016; Ward, Heidrich, & Clark, 2009). Additional mental health disorders include anxiety, panic attacks, phobias, sleep disorders and posttraumatic stress disorder (Copeland & Butler, 2007). An individual's perception of the world is often shaped by society and culture

(Brown & Keith, 2003). Several social and cultural reasons have been noted for the low utilization rates of Black women in mental health treatment: stigma, distrust of providers, being misunderstood and/or misdiagnosed, mistreatment, the attribution of being a *strong Black woman*, generational perceptions of therapy, racism, lack of African American researchers, money and insurance issues, poverty, and culturally defined help-seeking behaviors (Copeland & Butler, 2007; Gibbs & Fuery, 1994; Neal & Turner, 1991; Roberta & Priscilla, 2007). Copeland and Snyder (2011) add transportation, childcare, convenient hours as visible barriers to treatment.

In addition to avoiding treatment for social and cultural reasons, and unmet cultural, ethnic, and gender needs, Black women may delay treatment or withdraw early (Jones & Sheftall, 2015). Thus, some Black women do not engage with the healthcare system. As mentioned, this is both a problem of access and use, understanding that there are a variety of hurdles and challenges for Black women seeking mental health services. The problem is that Black women, for a variety of reasons, do not often engage in mental health services.

Much of the research to date has centered on the barriers and negative experiences of Black women in mental health (see Jones & Guy-Sheftall, 2015; McNair, 1996; Ward, Clark & Heidrich, 2009). Black women engage in mental health services at a lower rate than their White counterparts (Copeland & Butler, 2017). Understanding and addressing Black women's cultural context can be helpful in diagnosing and treating their mental health needs (Walton & Shepard-Payne, 2016). Further research is needed to explore the experiences of Black women who *do* access mental health services, and to understand

what opportunities, motivations, and experiences—over and above financial or cultural barriers—enabled them to voluntarily and successfully enroll and be treated.

In addition, though much of this research on Black women's experiences in mental health services presents important findings, no researchers have focused on the *positive outcomes* of Black women who have voluntarily used mental health services. But such research is warranted to address the documented problem of low mental health utilization among Black women (Copeland & Snyder, 2011).

Purpose of the Study

The purpose of this phenomenological study was to explore the lived experiences of Black women who voluntarily engage in mental health services. In this study, I sought to understand the experiences and outcomes of Black women who use mental health services, for example, what experiences and precipitating factors led to voluntary mental health treatment, and what coping skills or other therapeutic methods were used before seeking mental health treatment. Because withdrawal is a continual barrier to treatment, I focused on women who completed treatment (see Jones & Sheftall, 2015).

Research Question

What are the lived experiences of Black women who voluntarily engage in mental health services?

Conceptual Framework

The conceptual base for this study was critical race theory (CRT) and Black Womanist Thought. CRT was developed by several young scholars of color such as Derrick Bell, Mari Matsuda, Charles Lawrence, and Kimberlé Crenshaw, as well as

White theorist, Alan David Freeman. CRT is used to examine race and racism within areas such as law, education, and mental health (Brown, 2008; Howard-Hamilton, 2003). CRT helped to examine the racial inequalities in mental health treatment and how these inequities contribute to barriers to mental health treatment for Black women (Brown, 2008). The tenets of CRT are the permanence of racism; experiential knowledge (and counter-storytelling); interest convergence theory; intersectionality; Whiteness as property; critique of liberalism; and commitment to social justice (Delgado & Stefancic, 2017); McCoy & Rodricks, 2015). CRT uses counterstories to confront the narrative and myths of the dominant group (Howard-Hamilton, 2003). Counter-storytelling is used in this study to allow Black women to tell their narratives about their use of mental health services. Storytelling has been used historically in the Black community to exchange information. Due to once having limited communication avenues, storytelling and oratory were used to exchange ideas and important life-changing information dating back to slavery. Counternarratives are essential in this study because they balance the themes that have kept Black women from engaging in mental health services.

Using the Black Womanist Thought framework, a term coined by Alice Walker (1983), Black women can shape and narrate their experiences (Howard-Hamilton, 2003). Tenets of the Black Womanist Thought are the role of race, class, and gender in the lives of women. Black Womanist Thought further highlights the uniqueness, diversity, and struggle of the Black woman (JoAnne, 2000). This theory is important because it gives validity to Black women telling their story in what is coined as *herstory* (Lindsey-Dennis, 2015). It is important to capture their story using their voice. Using components of CRT

and Black Womanist Thought, this study examined how race, stigma, and gender (Copeland & Snyder, 2011; Neil & Turner, 2000; Ward, 2005; Ward, Heidrich & Clark 2009) play a role in the decision to engage in mental health services.

Nature of the Study

The approach to this study was a phenomenological. I sought to explore and understand the lived experiences and outcomes of Black women who voluntarily enter mental health services. This study is aligned with a qualitative phenomenological study design because the goal is to understand the lived experiences of participants experiencing or engaging in a specific phenomenon see Edward & Welsh, 2011). This type of data cannot be quantified as it must be understood through the documentation of stories and experiences, not relationships between variables. Using a qualitative design, I sought to gain a deeper understanding of the Black woman's experience with mental health services. A qualitative design also allows the participants to be observed in their natural setting. The Black woman’s experience is unique.

The phenomenological study design is a commonly used design in social and health sciences (Edward & Welsh, 2011). The phenomenological study allows researchers to examine lived experiences in the pattern of everyday life (Edward & Welsh, 2011). A strength of the phenomenological study is the interpretation of lived experiences (Munhall, 2007). Phenomenological studies involve the use of interviews with participants. The phenomenological study design aligns with the purpose and research question outlined here in several ways: (a) the subject of the study is an

individual (b) I focused on the lived experiences of Black women who use mental health services, and (c) the data collection tool was face-to-face interviews.

There were four criteria to participate in this study: (a) a woman who identified as Black, (b) was 18 years of age or older, (c) who continuously and voluntarily used mental health services for at least 3 months, (d) and who was discharged from mental health services. Participants were recruited by invitation via a flyer distributed in community locations such as libraries, coffee shops, and other businesses in Fairfield and New Haven counties in Connecticut.

The sampling strategy I used in this study was purposive sampling because it afforded greater control over the selection process as opposed to quantitative research (Barbour, 2001). When using purposive sampling the researcher purposefully selects candidates who could contribute to the study based on their experiences. The two types of purposive sampling that were used were criterion and snowball. Criterion sampling is used to recruit participants who meet specific requirements (e.g., Black women who voluntarily engage in mental health services). Due to the low participation rate of Black women in research, snowball sampling was used (Scharff et al., 2015). Snowball sampling is when participants are asked to recommend additional participants. The first participant was recruited through local advertising. Snowball sampling was used thereafter.

I was contacted by the candidates for a brief, prestudy interview. During the prestudy interview, I administered a demographic survey and inquired about the participant's use of mental health services. There is no method to cross-reference race,

ethnicity, and the use of mental health services; these were listed as self-reported. If the information was vetted, the participant was selected to enter the study.

The data collection used individual face-to-face interviews, lasting 60-90 minutes. The participant chose the location. The participant was asked a series of open-ended questions about access to mental health services, use of services, barriers to services, and outcomes of mental health services.

It is difficult to determine the sample size for qualitative studies. Onwuegbuzie and Leech (2007) noted that sample sizes for qualitative studies should not be too large, such that data cannot be extracted; however, they should not be too small, such that saturation cannot be accomplished. The sample size for a phenomenological study is between 3-10 participants (Starks & Trinidad, 2007). In a phenomenological study on African Americans overcoming barriers to therapy, Hall and Sandberg (2012) used a sample size of six (which also included men). According to Marshall (1996), an appropriate sample size is one that properly and adequately answers the research question. For this study, the sample size was six. Saturation was achieved when the participants yielded no new data (Saunders, Sim, Kingstone, et al., 2018).

Within the phenomenological approach, I focused on hermeneutical phenomenology (Laverty, 2003), as developed by Martin Heidegger on the premise of interpretation and developed meaning (El-Sherif, 2017). Hermeneutical phenomenology studies people (Sloan, Bowe & Brian, 2014) and considers the researcher to be a vital part of the research; the researcher is immersed in the world of the participant (El-Sherif, 2017). I chose this design because it is different from, say, transcendental

phenomenology (see Moustakas, 1994), in that it values the use of the researcher as a tool in research and acknowledges the use of the researcher's foreknowledge of a subject and ability to interpret data (El-Sherif, 2017).

Definitions

Black women: The term Black generally refers to a person with African ancestral origins (Agyemang, Bhopal, & Bruijnzeels, 2005).

Direct care: Direct services consists of diagnostic and problem evaluation, crisis intervention, individual, group and family psychotherapies, supportive counseling, prescription of psychoactive medication, and post-hospital care for the chronically mentally ill in the community (Institute of Medicine, 1979).

Intersectionality: A term used to address and analyze unique experiences of Black women in the United States of America. Intersectionality illuminates the interconnectedness of race and gender in social context, specifically in reference to Black women (Rodo-de-Zarate & Baylina, 2018).

Mental health services: Mental health services (primary mental health services) are defined in terms of direct and indirect care to patients with mental disorders in ambulatory settings (Institute of Medicine, 1979).

Mental illness: Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these) (American Psychiatric Association, 2018).

Stigma: An attribute that is deeply discrediting. A characteristic, behavior, or identity seen as incongruous with our stereotype of what a given type of individual should be (Goffman, 1963, p3).

StrongBlackWoman: An ideal, rooted in slavery, that is believed to represent the strength, tenacity and caretaking abilities of a Black woman (Stanton et al., 2017).

Psychotherapy: Psychotherapy, or talk therapy, is a way to help people with a broad variety of mental illnesses and emotional difficulties (American Psychiatry Association, 2016).

Assumptions

Assumptions are elements of the study that are relevant and out of the researcher's control (Simon, 2011). For this study, there were five assumptions: (a) all participants took part without coercion, promises, benefit, or payment; (b) all interviews, survey data, and personal accounts were accurate and true to the best of the participant's knowledge; (c) all data were presented in its purest form; I did not manipulate or alter the data in any way; (d) my personal opinions, beliefs, and background did not interfere with the process or interview data; (e) each participant used her individuality, words, and dialect to answer all interview questions.

Scope and Delimitations

Delimitations are characteristics of the study that are within the control of the researcher, however, further influencing the scope of the study (Simon, 2011). Delineations include time, space, location, research topic and questions, theoretical framework and targeted populations.

In this study, I examined the outcomes of Black women who voluntarily used mental health services. All participants were Black women, 18 years or older, and had previously voluntarily used mental health services. This study excluded Black men and women of other ethnicities and races. This study was narrowed to only Black women who live in New Haven or Fairfield Counties in Connecticut.

Limitations

The purpose of this study was to explore the lived experiences of Black women who voluntarily engaged in mental health services. The study was subject to several limitations. The first limitation was geographic location. The participants for this study were recruited from urban communities in New Haven and Fairfield Counties; thus, the results may not be transferrable to Black women from suburban or rural communities. The second limitation was the scope of this study combines the intersection of race and gender. Participants must identify as Black and female. Therefore, no interpretations can be made about males or other races. The third limitation was small sample size. The sample size for this study is six. The sample size decreases the transferability of the data.

Lastly, in qualitative research, the researcher is a critical part of the research process and that her bias can play a role in the observation and analysis of the research. I am both a Black woman and a Licensed Clinical Social Worker. I had no prior connections or acquaintance with any of the participants. To lessen personal bias, I kept a reflective journal. Additionally, all participants were offered a copy of the data so that they could ensure the accuracy of their part of the transcript.

Significance

The results of this study may have significant implications for both research and social change. To date, though much research has been done on the access and utilization rates of Blacks and mental health services, in exploring the barriers to each, no researchers have examined the lived experiences of Black women who voluntarily sought out and completed mental health treatment. This study will contribute to the body of research on Black women and mental health; it is expected to add a counternarrative about Black women who voluntarily seek mental health services by exploring their experiences with accessing, using, and completing treatment.

This study could affect positive social change by providing data from Black women that could assist in understanding the entire narrative of Black women who engage in mental health services. This study explored the problem of low utilization rates of mental health services among Black women, revealing, positive experiences to increase voluntary mental health usage (see Copeland & Snyder, 2011). The results could provide insight and guidance for Black women who would like to seek mental health services but have encountered barriers, and potentially women in general, as both see a low utilization rate with mental health services.

Summary

Low use of mental health services continues to be a problem among Black women (SAMHA, 2017). Barriers to mental health services are social and cultural — for example, stigma, distrust of providers, fear of being misunderstood or misdiagnosed, mistreatment, racism, judgment, insurance, location, and the attribution of being a

StrongBlackWoman. Much of the research to date has centered on the barriers and negative experiences of Black women in mental health (see Jones & Guy-Sheftall, 2015; McNair, 1996; Ward, Clark & Heidrich, 2009). Understanding and addressing Black women's cultural context can be helpful in diagnosing and treating their mental health needs (Walton & Shepard-Payne, 2016). In this study, I provide a counternarrative on the positive outcomes of Black women voluntarily engaging in mental health services.

In Chapter 2, I provide a synthesis of literature and evidence that supports the relevance of the problem. In Chapter 3, I explain the research methods that were used in the study. In Chapter 4, I explain the results of the study and in Chapter 5 I offer a summary, conclusion, and recommendations for future research.

Chapter 2: Literature Review

Introduction

Mental health in the Black community is highly stigmatized. Stigma, along with other social and cultural factors, are barriers to Black women seeking mental health treatment. The problem of low mental health utilization rates among Black women has been extensively researched, thus, providing data on why Black women do not seek out mental health services.

The purpose of this phenomenological study was to explore the lived experiences of Black women who voluntarily engage in mental health services. In this study, I addressed the problem of their low engagement with mental health services. I sought to understand the experiences and outcomes of Black women who use mental health services, to understand what experiences and other factors led to voluntary treatment, to coping skills, and to other therapeutic methods used before seeking mental health services. Because completing treatment is a continual challenge, I enrolled only those who completed treatment (see Jones & Sheftall, 2015).

As stated, Black women engage in mental health treatment at a lower rate than White women (U.S. Department of Health and Human Services Maternal and Child Health Bureau, 2013). Most research to date focuses on the barriers that Black women encounter seeking mental health treatment. Previous research also illuminates the prevalence of mental illness in the Black community, more specifically among Black women. Despite the many barriers that deter Black women from seeking treatment, there is a population of Black women that have overcome the barriers and successfully

engaged in, and completed, mental health treatment. This study sought to provide balance to the existing narrative on Black women and mental health and provide insight and guidance to others who may want to engage in mental health services but do not know how.

I must first conduct a review of the existing literature. A literature review is important to establish the research problem and the methodology. This chapter begins with an explanation of search strategies and the conceptual framework for the study.

I have organized the review of literature into six sections: (a) the history of mental illness in the Black community, (b) Black women and mental health, (c) barriers to mental health services, and (d) race and culture; (e) the etiology of mental illness and the various types of counseling; (f) the gaps in the literature and the need to include Black women in future mental health research. This study fills the gap in the literature by adding a counternarrative, that is, examining the positive outcomes of Black women who voluntarily engaged in mental health services.

Search Strategies

To identify prospective, peer-reviewed articles (as well as books and grey literature), the following electronic databases were searched for the past 5 years: Google Scholar, ProQuest Central, PsycINFO, SocINDEX, Sage, CINAHL, and Medline. The following keywords were used: *Black women, African American women, mental health stigma, depression, help-seeking behaviors among Black women, emotional benefits, validation, lifestyle change, mental health services, coping strategies, seeking*

psychological help, and *empowerment strategies, strong black woman, resilience, historical trauma, slavery, faith, church, suffering,* and *Black traditions*.

Conceptual Frameworks

In this study, I used a combination of theory and concept to build my conceptual framework: critical race theory (CRT) and Black womanist thought. The two conceptual frameworks that I chose for this study are predicated on the notion that race matters in health care, more specifically, mental health care. Components of each framework are compatible with phenomenology. Combined, the frameworks take into account the intersection of race and gender. Due to this study having two prominent themes (race and gender), I used CRT and Black womanist thought as the conceptual frameworks.

Critical Race Theory

Developed by several young scholars of color such as Derrick Bell, Mari Matsuda, Charles Lawrence, and Kimberlé Crenshaw, as well as white theorist Alan David Freeman, critical race theory posits that race and racism plays a dominant role in the inequality in law, education and mental health (Simba, 2017). CRT was developed after much frustration with critical legal studies (CLS). CLS is a theory that suggests the law has inherit social biases and protects those which created it (Legal Information Institute, n.d.). Covertly discriminating against anyone who does not fit the profile of those who created the law. CLS failed to acknowledge the importance of race in decision making, laws and political decisions. Thus, CRT was developed to acknowledge race as a component of inequality. CRT also differs from CLS in that it is a social action theory. CRT wishes to change systems by implementing new laws and policies that are more

inclusive (Crenshaw 2005). Since the development of CRT during the civil rights movement, CRT has been adopted in other disciplines such as education and mental health. CRT in the field of mental health is still evolving. CRT is wide-ranging and developing in many disciplines. CRT has at least seven tenets (Delgado & Stefancic (2017); McCoy & Rodricks (2015): (a) the permanence of racism, (b) experiential knowledge (and counter-storytelling), (c) interest convergence theory, (d) intersectionality (e)Whiteness as property (f) critique of liberalism and (g) commitment to social justice.

The permanence of racism acknowledges that race and racism is an overarching aspect of Blacks and communities of color experiences (McCoy & Rodricks, 2015; Delgado & Stefancic, 2017). Permanence of racism also includes the concept of racial stratification. Racial stratification is defined as a hierarchy of racial groups, suggesting that one group is superior to another (Brown, 2003). In acknowledging racial stratification, one is forced to examine who and why the laws, policies, and guidelines are made. Racial stratification deems White's as the superior group.

Experiential knowledge values the lived experiences of Black people and communities of color. Solorzano and Yosso (2011) described the importance of experiential knowledge (story telling) as valued, legitimate, appropriate and critical to understanding, analyzing, and teaching about racial subordination. Storytelling is a historic and respected way to communicate information in the Black community.

Interest convergence theory, grounded in Marxist theory, postulates the agenda of racial equality for Black people or communities of color will only be acknowledged if it

aligns or benefits those in power. Brown and Jackson (2013) characterize those in power as White, male, Christian, and able-bodied. This tenet assumes that change or advancement for Black people or communities of color only happen when the change benefits White men in power. The benefit has to be mutual and converging among Black people and White men. Progress does not happen if the interest only benefits Black people or communities of color.

Intersectionality is defined as the interconnectedness of one's identities, specifically in Black women (Rodo-de-Zarate & Baylina, 2018). A term originally coined by Kimberlé Williams Crenshaw (1991) explores the multiple roles of Black woman and oppression. Crenshaw viewed the complexities of the everyday lives of Black women through the interconnectedness of roles and traits. Black women experience oppression because they are both black and women, the interconnectedness of gender and race. (McCoy & Rodricks, 2015). Through the lens of intersectionality, CRT examines forms of oppression through identities such as gender, race, sexual orientation, religion, class, physical or mental disability. No one has a single identity (Delgado & Stefancic, 2017) thus an examination of one's life should be viewed in totality taking into account all identities and interconnectedness.

Whiteness as property is the belief that being White and the privileges (possession, provision, use, transfer, disposition, and exclusion) associated with Whiteness are to be guarded and treasured (McCoy & Rodricks, 2015; Delgado & Stefancic, 2017). Moreover, the privileges are to be protected by the law. Whiteness as property is also known as white privilege. Peggy McIntosh (1990) defines white privilege

as an unearned advantage and conferred dominance. Whiteness as property illuminates the social advantages of being White and further enforces racial stratification. Racial stratification is defined as a hierarchical system of structured inequality, which makes one racial group superior to another (Verdugo, 2008). Moreover, racial stratification rewards or oppresses individuals based on their racial group membership.

The next tenet of CRT is the critique of liberalism. The critique of liberalism confronts the notion of color blindness and liberal transformation. Color blindness is the belief that race does not matter and that one should be treated equally regardless of race. CRT confronts this philosophy stating color blindness is another form of racism, failing to consider the permeance of racism (McCoy & Rodricks 2015). CRT also confronts concepts such as incremental change, objectivity and equal opportunity. CRT scholars challenge these concepts and notions in large part due to the dismissive and minimizing effect on race or racism. Transformation should be swift and aggressive (McCoy & Rodrick, 2015). Delgado and Stefancic (2017) note in order to remedy racism it first has to be acknowledged.

Lastly, commitment to social justice is a foundational pillar of CRT. Social justice in relation to CRT is defined as eliminating all forms of oppression, subordination, and stratification based on race, color, sex, ethnic belonging and religion (McCoy & Rodricks, 2015; Delgado & Stefancic, 2017). Expression of social justice would be visible in all domains: education, medical, political, social and economic.

CRT is integrated into this study using the following tenets: experiential knowledge, intersectionality, and commitment to social justice. The intersectionality of

being Black and a woman are key components of this study. Race is an exclusionary factor for minorities in the area of social, economics, medical, employment and education (Institute of Medicine, 2002; National Research Council, 2004). Race is a barrier that Black women have to face every day.

Black Womanist Thought

Black womanist thought is closely related to feminist theory. Feminist theory examines topics, assumptions, and social issues from a female perspective, as opposed to the dominant male perspective (Lindsay-Dennis, 2015). Feminist theory focuses on the unique concerns and issues of women. It considers the consideration of a woman's viewpoint and gives women a voice. Feminist theory challenges the injustice and inequalities of women when compared to men on topics such as gender equality, gender differences, and oppression.

Womanism, a concept introduced by Walker (1983), is used to examine social and cultural issues related to Black women. Womanist thought is a theoretical framework created by and for Black women (Joanne, 2000). The terms *womanism, Black feminist thought,* and *womanist theory* have been used interchangeably throughout several studies to define the lens in which best articulate the Black woman's standpoint (Joanne, 2000). In this study, the term used is Black womanist thought.

Tenets of Black womanist thought include the intersection of race, class, and gender; all of which contribute to oppression and racism. Howard-Hamilton (2003) noted three themes exclusive to the Black womanist thought. First, it is shaped by the experiences of Black women. Black womanist thought recognizes the unique experiences

of Black women. For so long, others have framed the experiences of Black women. Black womanist thought allows the Black woman to frame and tell her own story. Second, while every experience and story among Black women is unique, there is a thread of intersection that is common among Black women. Third, diversity (class, age, religious affiliation, economic factors, and sexual orientation) among Black women provide multiple contexts for their experiences to be understood. Howard-Hamilton (2003) suggests both, Black womanist thought and CRT are promising theoretical frameworks when seeking to understand the intersecting identities of Black women.

Using the Black womanist thought framework, Black women can shape and narrate their experiences (Howard-Hamilton, 2003). Tenets of the Black womanist thought are the role of race, class, and gender in the lives of women. Black womanist thought further highlights the uniqueness, diversity, and struggle of the Black woman (JoAnne, 2000). This theory is important because it gives validity to Black women telling their story in what is coined as *herstory* (Lindsey-Dennis, 2015). It is important to capture their story using their voice. Using components from CRT and Black womanist thought this study would examine how race, stigma, and gender (Copeland & Snyder, 2011; Neil & Turner, 2000; Ward, 2005; Ward, Heidrich & Clark 2009) plays a role in the decision to engage in mental health services.

Mental Illness

Prevalence of Mental Illness in the United States

Mental illness is a crisis in the United States (Mental Health America, 2018). The Substance Abuse and Mental Health Services Administration defines *mental illness* as a

disorder that affects thinking, mood, and behavior. Mental illness includes three categories: any mental illness, serious mental illness and severe mental illness. *Serious mental illness* seriously limits or interprets one's daily functioning (National Institute of Mental Health, 2017). *Severe mental illness* defined by its duration and degree of disability (Hazelden Publishing, 2016).

The rates of mental illness in the United Sates continues to rise. In a study conducted by Mental Health America (2018) it was found that suicidal ideations in adults have increased from 3.77% to 4.04 %. Over 9.8 million Americans experience serious suicidal thought; this number has increased since 2018 by 200,000. In 2016, there were an estimated 10.4 million adults aged 18 or older in the United States with serious mental illness (National Institute of Mental Health, 2017). Serious mental illness is higher among women (5.3%) than men (3.0%) (National Institute of Mental Health, 2017).

Moreover, major depressive episodes in youth ages 12-17 have risen from 8.66% to 12.63 % between 2017-2018; this number has increased by 175,000. Over 2 million youth a year cope with major depression (Mental Health America, 2018). 18.07% of adults are experiencing a mental illness, roughly 44 million American. Of the 18.07%, 41.3 % are experiencing a severe mental health illness (Mental Health America, 2018).

Where an individual lives can define the services he or she receives (Mental Health America, 2018). In the United States, 56.4% of adults with mental illness receive no treatment; appropriately 24 million people (Mental Health America, 2018). One out of five adults who were diagnosed with a mental illness were unable to receive the services needed (Mental Health America, 2018). This number has not declined in 7 years. Over

5.3 million people diagnosed with mental illness are uninsured (Mental Health America, 2018). This number has decreased by 2.5% between 2017-2018 due to the Affordable Care Act. While the Affordable Care Act has enabled people to gain access to insurance; however, there are still barriers to care and mental health disparities.

History of Mental Illness in the African American Community

The Diagnostic and Statistical Manual of Mental Disorders V (American Psychiatric Association, *DSM-5*, 2013) defines a mental disorder as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (p. 20). Mental disorders are not relegated to one group or community. Mental disorders have a prevalence among all cultures, races, and ethnicities. However, there are some disorders that have a higher prevalence among the Black community, more specifically Black women. Blacks are more likely to be diagnosed with psychotic disorders such as schizophrenia (Buser 2009; Constantine et al., 2007; Schwartz & Feisthamel, 2009; U.S. Department of Health and Human Services, 2014).

Furthermore, Blacks are also more likely to be prescribed psychotropic medication and hospitalized than Whites (Buser 2009; Constantine et al., 2007; Schwartz & Feisthamel, 2009; U.S. Department of Health and Human Services, 2014). According to the U.S. Department of Health and Human Services (2014) and the National Alliance on Mental Illness (2015) Blacks are 20% more likely to experience psychological distress than Whites. The National Center for Health Statistics (2012) report Black women

suffered from sadness more than White women. The most common mental health disorders among Blacks are Attention Deficit Hyperactivity Disorder (ADHD), depression and Post Traumatic Stress Disorder (PTSD), (NAMI, 2015).

Despite having a higher prevalence of ADHD, depression, and PTSD, Black women seek mental health services at a lower rate than White women (U.S. Department of Health and Human Services Maternal and Child Health Bureau, 2013). The problem lies in access and use.

Mental Illness in Black Women

Understanding who Black women are adds context to the discussion on Back women and mental illness. According to the 2013 Census Bureau numbers, the Black female population totaled 23.5 million, 52% of the total Black population. Black women ages 16-64 have higher rates of unemployment when compared to all women and have a higher poverty level than other women (Census.gov, 2013). The U.S. Census Bureau (2013) also reported that 29% of Black women are the head of households compared to all women at 13%. Moreover, there is a drastic difference in comparison in relationship status and single parent births among Black women and all women. The noted social, environmental, and cultural differences between Black women and other women lead to stressors that can induce mental health issues (Census.gov, 2013).

Black women face multiple intersections, including health conditions, that have a bearing on their mental health status (Lacey et al., 2015). Jones and Guy-Sheftall (2015) added that busy lives, work schedules, and domestic responsibilities as stressors that lead to mental health issues in Black women. Multiple oppressions such as classism, racism,

sexism, and heterosexism as a societal stressor which cause undue stress and mental strain. Jones (2015) note issues surrounding mental health treatment for Black women are complex and controversial. In a study conducted by Schultz, Israel, Williams, Parker, and James (2000) found that Black women experience greater morbidity and mortality at a younger age from stress and stress-related diseases than White women. Moreover, Schulz et al., suggested the difference in socioeconomic status, unfair and unjust treatment, racism and both chronic and acute life events such as the death of a loved one or ongoing challenges such as discrimination are significant factors in the racial differences in women's health status. Intersectionality calls for one to understand Black women as a whole inclusive of their socioeconomic status, health status and culture. It is important to understand Black women from all intersections.

Mental Health Services

Mental health services are an umbrella which covers many different avenues of intervention and assistance. Mental health services include assessments, diagnosis, treatment or counseling by a trained professional to assist an individual or group in alleviating mental or emotional illness, symptoms, conditions or disorders (Baylor College of Medicine, 2005). Trained professionals include licensed social workers, nurses, psychiatrist, licensed professional counselor, marriage and family therapist, clergy, and psychologist. This section of the literature review focuses on the diverse approaches to providing mental health services.

Counseling (Therapy)

There are several methods to address mental illness. Counseling is a common method used to address mental health. *Counseling* is defined as a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals (Kaplan, Tarvydas, & Gladding, 2014). The term *counseling* is interchangeable and often referred to as *therapy*. There are several types of counseling. Each type of counseling is unique to a specific issue. The four main types of counseling are individual counseling, couples counseling, family counseling and, group counseling. Individual counseling is one to one counseling, developed to assist with life stressors such as life transitions, depression, and, anxiety. Couples counseling, also known as marriage counseling, is designed for relational matters in intimate relationships or marriages. Family counseling is used to address changes or stress affecting a family. Such issues can include parent/ child problems, sibling problems, life transitions, and grief or loss. Any issues that affect the familial system can be addressed in family therapy. Lastly, group counseling, usually between 8 and 12 participants, meet with a group leader to discuss a predetermined topic. The premise of group counseling is that the participants do not feel alone in the situation (American Counseling Association, 2019). Counseling is a common approach when dealing with diverse mental health issues.

Psychology Today (2019) defines *psychotherapy* as the practice of spending time with a trained professional—usually a psychologist, a social worker, or a licensed counselor—to help diagnose and treat mental and emotional problems, as well as talk

through everyday difficulties. Studies suggest that psychotherapy is an effective method to treat a wide range of mental illnesses (NAMI, 2019). Psychotherapy, otherwise known as talk therapy, started in ancient times. Psychotherapy became notable in 1882 by Physician Josef Breuer (Wilson, 2018). Josef Breuer found that while discussing a client's symptoms and tracing them back to their origin the symptoms would disappear.

Since this discovery, psychotherapy has grown rapidly. There are now over 400 psychotherapeutic approaches (Wilson, 2018). Wilson (2018) describes psychotherapy as both an art and a science. One of the driving forces of psychotherapy is the therapeutic alliance. The therapeutic alliance is the rapport and relationship between the therapist and the client. The therapeutic alliance coupled with empathy, interpersonal warmth, acceptance and, genuineness helps to make psychotherapy effective (Wilson, 2018). While there are vast psychotherapeutic approaches, it is the therapeutic alliance that makes the difference.

Psychotherapy can be used for short term (weeks to months) or long-term treatment (months to years). Approximately 75% of people who have used psychotherapy report benefitting from it in some way (American Psychological Association, 2016). According to the American Psychological Association (2019) benefits of psychotherapy include improvement in emotions and behaviors and positive changes in the body. Moreover, studies have shown that psychotherapy can change the brain, changes similar to the use of psychotropic medication (APA, 2019). Psychotherapy is a trusted and effective method used in the mental health profession.

Informal Support Systems

In contrast to the formal types of therapy, there are also informal types of therapeutic support such as friends, family, and church social networks. There is limited literature on informal help-seeking behaviors of Black women. In the literature that does exist, data shows Black women prefer to seek help from informal supports such as social networks (Morrison, Luchok, Richter, & Parra-Medina, 2006). Informal social networks among Black women are comprised of sisters, friends, extended family, church members, neighbors and fictive kin (Morrison, Luchok, Richter, & Parra-Medina, 2006; Taylor, Chatters, Hardison, & Riley, 2001). According to Sosulski and Woodward (2013), Black women who have closer familial bonds are less likely to seek professional counseling and more likely to rely on their informal support systems. Informal support systems are important in the Black community. While informal support systems are important, in many ways, informal support systems are a barrier to professional support for Black women.

Spiritual Practices

The Black community relies heavily on the Black Church for important information. The Black Church is defined as Black denominations with predominately Black congregations including a Black clergy as the leader or senior pastor (Stewart, Sommers, & Brawner, 2013). In the United States, Blacks are the largest racial, religious group (Stewart et al.,2013). The church is used as a trusted social, political and healing setting dating back to slavery (Stewart et al., 2013). The Black community, more so, Black Christian women, rely on the church, clergy, and spiritual leaders to provide

guidance when in the time of trouble (Stewart et al., 2013; Mattis 2002). The Black church is a pillar in the Black community. Religion and spirituality are cornerstones and foundational methods in a Black women's array of coping skills (Mattis, 2002). Fasting and prayer are taught as ways to conquer problems and "to get through." Mattis (2002) noted prayer as the primary coping strategy even if the woman was not a part of organized religion. This type of informal support often delays Black women from seeking professional help for mental illness or traumatic life stressors.

Race and Culture

Race and culture are two facets that are intertwined when treating Black women in clinical services. The absence of recognition of either, race or culture, can be a barrier to Black women engaging and/ or remaining in mental health treatment (Campbell & Long, 2014; McNair 1996; Cole, Stevenson & Rogers, 2009). Culture is defined as the totality of socially transmitted behavior patterns, arts, and beliefs (McNair, 1996; Purnell & Paulanka, 1998). Culture has a significant impact on decision making, shaping beliefs, communication, values, laws, and rules (Cole et al., 2009). Black culture is learned and passed down from generation to generation via stories, myths, and behaviors (McNair, 1996). Through the lens of culture illness is defined, experienced, and interpreted (Cole et al., 2009). What is deemed normal or abnormal behavior is based on one's cultural understanding of the behavior. Stigma, fear, silence, Strong Black woman concept, and distrust of the medical system are all cultural ideologies in the Black community.

Culture guides how Black women view and use mental health services (McNair, 1996; Cole et al., 2009). In contrast, culture also guides how Black women cope with

stressors—for example, waiting to engage in professional services, practicing the characteristics of the Strong Black Woman, and using informal supports as a way to cope. Thus, culture shapes behavior. As stated, Black women face multiple barriers to accessing mental health treatment and are faced with environmental and cultural factors that increase their chances of developing a mental disorder.

Mental Health and Black Women

As previously mentioned, issues surrounding mental health treatment for Black women are complex and controversial (Jones, 2015; Jones, Hopson, Warner, Hardiman & James, 2015). Blacks, more specifically, Black women, face multiple barriers when seeking mental health services. Blacks encounter more barriers to mental health services than their White counterparts (U.S. Department of Human Services, 2001). Barriers to mental health services for Black women include stigma, lack of diversity, misdiagnosis, shame, John Henryism, mistrust of the healthcare system, access, affordability, being labeled as a StrongBlackWoman, race, and health (Sosulski & Woodward, 2013; Neal-Barnett & Crowther, 2000; Ward & Heidrich, 2009; Awosan, Sandberg & Hall, 2011). While this list is not meant to be exhaustive, it does capture many of the main barriers that Black women face when seeking mental health services.

Stigma and shame. Stigma surrounding mental health diagnosis and treatment is prevalent in our society (Ward & Heidrich, 2009). The prevalence of stigma associated with mental health is heightened in communities of color. Goffman (1963) defines stigma as any attribute that is discrediting. Stigma can be a characteristic, behavior, or identity labeled as "incongruent" with what an individual or group should be (Campbell and

Mowbray, 2016). Stigma can be seen in the form of distancing, isolating, labeling, talking down, discrimination, ridiculing, and ostracizing. The need to seek treatment in the Black community is often set aside or ignored due to stigma and the fear of not being viewed as independent or strong. The stigma surrounding mental health treatment and the need to seek services can lead to feelings of shame, fear, guilt, embarrassment, and frustration (Allen, Davey, & Davey, 2010). Stigma is a known concept across many races and cultures; however, racial/ethnic minorities often suffer the most (Campbell & Mowbray, 2016). Stigma and shame are noted as barriers to mental health services for Black women (Campbell & Mowbray, 2016; Awosan, Sanberg, and Hall, 2011; Allen et al., 2010).

John Henryism. Active coping or high effort coping is also a barrier to treatment for Black women. John Henryism, a concept developed by Sherman James (1983), is a form of active coping. John Henryism, named after a legend by the name of John Henry, is a strong behavioral predisposition that believes environmental and psychosocial stressors can be changed by hard work and determination (James, 1994; Stevens-Watkins, Sharma, Oser, Leukefeld & Knighton, 2013; Clark, Adams & Clark, 2001; Kramer, Johnson & Johnson, 2015; Bronder, Speight, Witherspoon, & Thomes, 2015) . Moreover, John Henryism posits if one works hard enough, the psychosocial and environmental stressor will be lessened and overcome. The concept of John Henryism is based on a folklore tale (scientific literature) of John Henry, the steel-driving man and the story of John Henry Martin, a retired Black Farmer, in the early 1900s. Guy B. Johnson (1927) and William (1983) noted John Henry, in the 1870s beat a mechanical steam drill

in a steel-driving contest; however, subsequently died of mental and physical exhaustion (James,1994; Kramer, Johnson & Johnson, 2015).

The same hard work and determination were depicted in the life of John Henry Martin. John Henry Martin, the retired Black farmer, gained freedom from the exploitive sharecropping system in North Carolina. John Henry's active coping skills (hard work, will, and determination) freed himself and his family from debt and led to generational wealth by owning 75 acres of land by the time he was 40 years old. Once again, the determination, will, and hard work came with a price. John Henry suffered from many physical ailments, including hypertension, arthritis, peptic ulcer disease.

Bronder, Speight, Witherspoon, and Thomas (2014) found John Henryism more prevalent in Blacks than whites. The prevalence of John Henryism is increased in Blacks due to the daily psychosocial stressors and the perception of being strong and able to handle stress. Black women set a high expectation for themselves and their internal and external abilities, which in turn, minimizes psychological stress, depressive systems, and anxiety triggers (Bronder et al., 2014). It is with this embedded perception of Black women that a cultural barrier to mental health services is created and upheld.

StrongBlackWoman. Sociohistorical events, coupled with cultural views on mental health and help-seeking behaviors, have caused Black women to adopt unhealthy coping skills. The concept of a StrongBlackWoman, superwoman schema, and Sojourner Syndrome (Lekan, 2019) are illustrations of current models of coping. All of the above-mentioned coping approaches for Black women are considered barriers to seeking mental health services (Melissa Harris-Lacewell, 2001; Cheryl Wood-Giscombe et al., 2016;

Bronder et al., 2014; Harrington et al., 2010Cheryl Woods-Giscombe, 2010; Donovan & West, 2015; Watson & Hunter, 2016). The three illustrations noted above all have similar characteristics, strength, and caregiving; thus, one term, StrongBlackWoman, is used throughout this study.

StrongBlackWoman is an ideology grounded in the perception that a Black woman is strong (physically and emotionally), independent, a caretaker, tenacious, self-efficacious, self-sacrificing, self-contained, and resilient (Bronder et al., 2014; Donovan & West, 2015; Stanton et al., 2017; Watson & Hunter, 2016);Woods-Giscombe, 2010). Melissa Harris Lacewell (2001) refers to strong Black woman image as superhuman. The StrongBlackWoman concept has been internalized by Black women and guides how decisions are made (Woods-Giscombe, 2010). The illusion of StrongBlackWoman originated during slavery (Harrington, Crowther, Shipherd, 2010). During slavery, Black women were perceived to be stronger and more resilient, both physically and psychologically, than White women (Harris- Lacewell, 2001; Stanton et al., 2017). The illusion of StrongBlackWoman was used to justify harsher punishment and acts of sexual violence against Black women (Stanton et al., 2017). Since slavery, the illusion of StrongBlackWoman resonated with Black women. StrongBlackWoman has become a doubled-edged sword (Woods-Giscombe, 2010).

The StrongBlackWoman ideology can be viewed as an asset and a liability. Watson and Hunter (2016) note the relationship between the benefits and assets of StrongBlackWoman to be tenuous. Black women face gendered racism, sexism, oppression, and discrimination daily (Donovan & West, 2015; Woods-Giscombe, 2010).

The difficulties faced by Black women are steeped in race, gender, and socioeconomic status and necessitates the need for a Black woman to be a StrongBlackWoman (Watson &Hunter, (2016). The accumulation of these stress factors results in what Arline T. Geronimus (1992) titled weathering. *Weathering* is the wear and tear of incessant exposure of social and political adversity in the Black community, which results in early health deterioration. The characteristics of StrongBlackWoman help Black women to face these difficulties. The ability to persevere, push through, multitask, lead, and care-take has been used as an effective coping strategy (Bronder et al., 2104).

StrongBlackWoman is a coping strategy used to maintain and sustain the African American family and community (Woods-Giscombe, 2016; Harris Lacewell, 2001). The StrongBlackWoman schema has been viewed as a badge of honor and an affirming symbol in Black girl and womanhood (Watson & Hunter, 2016; Stanton et al., 2017; Harris-Lacewell, 2001). While the StrongBlackWoman persona has been effective for the survival of the African American community, it comes with a physical and psychological cost (Woods-Giscombe, 2016; Harris Lacewell, 2001). Harris-Lacewell noted three liabilities of the StrongBlackWoman persona: 1. The strain on interpersonal relationships, 2. stress-related health behaviors, and 3. embodiment of stress. This study focuses on the liability of internalizing StrongBlackWoman, thus becoming a barrier to mental health treatment.

Distrust. Blacks have a long history of not trusting the medical system, mental health practitioners alike (Copeland & Snyder, 2011). Social historical events such as the Tuskegee Study of Untreated Syphilis in the Negro Male also known as the Tuskegee

Experiment (1932-1972) has led to the Black community's distrust of the medical system (Ward et al., 2009). In 1932, the Public Health Service in partnership with the Tuskegee Institute, under the guise of treatment for "bad blood" 201 men were infected with syphilis without there informed consent (Centers for Disease Control and Prevention, 2015) in exchange for free medical, food and death benefits. The intent and purpose of the study were not disclosed to the participants. The total study involved 600 participants. A study that was supposed to last six months lasted 40 years.

In addition, sociopolitical history is also believed to foster a negative attitude toward the medical system (Ward et al., 2009). The negative attitudes towards the medical system have become a cultural-historical belief that has been passed down from generation to generation in the Black community. The Black community's distrust of the medical system includes fear of being misdiagnosed, negative perceptions, unauthorized experiments or treatment, fear of hospitalization, medication and losing control (Copeland & Synder, 201; Jones et al., 2015; Jones, 2015; Jones & Guy-Sheftall, 2015; Carrington, 2006). Losing control is a fear in the Black community, especially among Black women, due to the ideology that Black women are in control and strong. Blacks are misdiagnosed, hospitalized, and involuntarily committed at a higher rate than Whites (Jones et al.,2015; Feisthamel & Schwartz, 2009). Thus, becoming a barrier for Black women engaging in mental health services.

Cultural misunderstanding. In addition to systematic and social-historical barriers, there are other barriers that hinder Black women's access and usage of mental health services. Two barriers, in particular, are the poor quality of care and cultural

matching. Ward and Heidrich (2009) define poor quality of care as limited access to culturally competent clinicians and case management. Cultural matching is the limited opportunities to work with clinicians of color (Ward & Heidrich, 2009). The inability to relate to medical professionals, especially mental health professionals, hinders the therapeutic process. Black women are often misdiagnosed and misunderstood (Carrington, 2006). Misdiagnoses come from the misinterpretation of the complexities and particularities of Black women and Black culture (Garretson, 1993). Black culture has become pathologized (Awosan, Sandberg & Hall, 2011). Standard diagnostic measures, which are widely used in determining abnormal or clinically significant behaviors, have been developed through a lens of European culture (Awosan et al., 2011). The term Eurocentrism is defined as a perception in which European (White) standards, values, norms, behaviors, and traditions are used to view and compare other races and behaviors (Helms, 1989; Jones 1997; Katz 1985; Awosan et al., 2011; Sue et al., 2009).

Standard diagnostic tools are not culturally sensitive to assess the symptoms or needs of Black women (Awosan, Sandberg & Hall, 2011). Blacks are diagnosed three to four times higher with psychotic disorders than Whites (Schwartz & Blankenship, 2014; Feisthamel & Schwartz, 2009) due to symptom misinterpretation. Additionally, the issue of cultural competency and matching is associated with distrust of the medical system and the power differential when entering a therapeutic relationship. Ultimately, when a Black woman does seek mental health treatment, services were prematurely terminated

due to the care provided by the mental health practitioners (Brown, 2003; Diala et al., 2000; Ward & Heidrich, 2010;).

Race and Health

The barriers to mental health treatment for Black women can be indicative of struggles in other areas such as physical health. For instance, the Strong Black Woman concept can be depicted in a Black woman's decision to seek out health services. Black women experience diabetes, obesity, hypertension, preterm birth, circulatory disease, and HIV/AIDS at a higher rate than any other race or ethnic group (Braveman, 2012; Walker-Barnes, 2014). Black and White women have similar rates for cancer; however, Black women die from cancer at a higher rate than White women. Additionally, Black women have a lower life expectancy than any other ethnic group (Walker-Barnes, 2014). This is known as health disparities. Health disparities are defined as the differences in health between race or ethnic groups (Braveman, 2012). According to Paula Braveman (2012) health, ethnic disparities in the United States has always existed, the largest gap being between Blacks, American Indians and Whites. Whites fairing far better than Blacks. Health disparities are also noted between Latinos and Whites (Braveman, 2012). Whites are usually in the best health. There is a close connection between physical and mental health in Black women. Mental health affects physical health and physical health affects mental health. The synonyms, perceptions, and behaviors should be considered when treating with Black women.

Summary

Black women engage in mental health services at a lower rate than White's (American Psychiatric Association, 2017). Low engagement of Black women in mental health services is due to a problem of access and use. The problem of use of mental health services among Black women is comprised of cultural, social, and systemic barriers. Black women face a variety of hurdles and challenges when seeking mental health services. Researchers have presented compounded barriers as to why Black women do not seek mental health services. Moreover, researchers have argued the need for Black women to engage in mental health services. Due to the complexities of Black women and the barriers to mental health services, it is important to understand the experiences of Black women *who do* access mental health services, understanding what opportunities, motivations, and experiences, over and above financial or cultural barriers, enabled them to voluntarily, successfully enroll and be treated.

In Chapter 3, the methodology, research design, qualitative approach and rational, data collection method and analysis plan will be discussed.

Chapter 3: Research Method

Introduction

The purpose of this phenomenological study was to explore the lived experiences of Black women who voluntarily engage in mental health services. In this study, I addressed the problem of low engagement in mental health services among Black women. I sought to understand the experiences and outcomes of Black women who use mental health services, to understand what experiences and other factors led to voluntary treatment, to coping skills, and to other therapeutic methods used before seeking mental health services. Because completing treatment is a continual challenge, I enrolled only those who completed treatment (see Jones & Sheftall, 2015). In this chapter, I outline the research design and rationale, role of the researcher, methodology (including instrumentation), procedures for recruitment, and data analysis plan.

Research Design and Rationale

Research Question

What are the lived experiences of Black women who voluntarily engage in mental health services?

Design and Rationale

In this phenomenological study, I explored the lived experiences and the outcomes of Black women who voluntarily used mental health services and how these experiences affected their daily lives. This exploration aligned with a phenomenological design because the goal was to understand the lived experiences of participants experiencing or engaging in a specific phenomenon (see Edward & Welsh, 2011). This

type of data cannot be quantified; it can only be understood through the documentation of stories and experiences, not the relationships between variables. With a qualitative design, I could gain a deeper understanding of the Black woman's experience with mental health services and the participants could be observed in their natural setting. The Black woman's experience is unique.

Phenomenology is a qualitative research method designed to explore lived experiences of daily life (Burkholder, Cox, & Crawford, 2016; Edward & Welsh, 2011; Laverty, 2003), or how one relates to a phenomenon or the meaning people give to a phenomenon (Burkholder et al., 2016). According to Burkholder et al. (2016), a *phenomenon* is an event or experience that has happened to someone. Thus, a phenomenon can be described only by the individual who experienced it. Phenomenology is a method used to understand such experiences; it places an experience in a context and examines transferability (Burkholder et al., 2016).

Phenomenology is based in 20th-century philosophy developed by Edmund Husserl (El-Sherif, 2017). There are two schools of phenomenology: transcendental (descriptive) and hermeneutic (interpretive). I used hermeneutical phenomenology (Laverty, 2003). Hermeneutical phenomenology was developed by Martin Heidegger on the premise of interpretation and developed meaning (El-Sherif, 2017). Hermeneutical phenomenology allows researchers to study people (Sloan, Bowe, & Brian, 2014). In addition, hermeneutical phenomenology considers the researcher to be a vital part of the research; the researcher is immersed in the world of the participant (El-Sherif, 2017). I chose this design because it is different from, say, transcendental phenomenology(see

Moustakas, 1994), in that it values the use of the researcher as a tool in research and acknowledges the use of the researchers fore-knowledge of a subject and ability to interpret data (El-Sherif, 2017).

The phenomenological study design is a commonly used design in social and health sciences (Edward & Welsh, 2011). The phenomenological study allows researchers to examine lived experiences in the pattern of everyday life (Edward & Welsh, 2011). A strength of the phenomenological study is the interpretation of lived experiences (Munhall, 2007). Phenomenological studies involve the use of interviews with participants. The phenomenological study design aligns with the purpose and research question outlined here in several ways: (a) the subject of the study is an individual; (b) I focused on the lived experiences of Black women who use mental health services; and (c) the data collection tool was face-to-face in-depth interviews.

Furthermore, a phenomenological research design is a better fit for this study as opposed to a generic, basic qualitative study. A generic, basic qualitative study explores an external process. More specifically, attitudes, beliefs, and reflections of an outer word (Percy, Kostere, & Kostere, 2015). For example, basic, generic qualitative research design explores one's experience with external happenings and events, how people make sense of the lives (Percy, Kostere, & Kostere, 2015). Phenomenology explores the internal cognitive processing of lived experiences (Percy, Kostere, & Kostere, 2015). For example, how it feels to be angry, judged or misunderstood. This study explored the social, cultural, and systematic barriers for Black women who seek mental health treatment and how they overcame the barriers to engage in mental health treatment.

Phenomenology is an interpretive approach to research (Patton, 2002). The interpretive approach (also known as a hermeneutic approach) is based on interpretation of an event (Matua & Van Der Wal, 2015). The interpretive approach is deeper than a descriptive approach. A descriptive approach describes while an interpretative approach adds meaning (Matua & Van Der Wal, 2015. The purpose of a phenomenological study is to explore and interpret the cognitive processing and meaning of a common experience of a phenomenon (Patton, 2002; Percy, Kostere, & Kostere, 2015; Matua & Van Der Wal, 2015).

Role of the Researcher

In qualitative research, the researcher is a critical part of the research process. Qualitative research is an interpretative process; the researcher is the interpreter (Stark & Trinidad, 2007; Tufford & Newman, 2010). Furthermore, the researcher is used as a key instrument in qualitative research (Burkholder et al., 2016). The researcher is the instrument for data collection. While additional tools such as questionnaires, observations, and documents may be used, all the information is examined through the lens and positionality of the researcher. The researcher also acts as an observer in the data collection process. As an observer, the researcher can read body language and cues. Body language and cues are referred to as nonverbal language. The researcher's role, background, gender, culture, socioeconomic status, and experiences shape the study, from inception to participant invitation and finally data collection (Coghlan & Brydon-Miller, 2014).

Reflectivity is an underrated and underexplored concept in qualitative research. Reflectivity happens when the researcher is aware of their biases, backgrounds, preconceived notions, and connections to the phenomena studied (Reflectivity, 2014). Moreover, reflectivity acknowledges that such connections, biases, and backgrounds can shape the study (Burkholder et al., 2016) It is important to acknowledge one's biases, assumptions, and connections to the study early on in the research process. To be *reflexive* means to be aware of potential researcher bias every step of the study. In qualitative studies, it is important to report assumptions, position, bias and values to the reader, more so, because the researcher's perspective and position shape the study. Journal keeping and reporting preconceptions and assumptions in the study are ways to foster a reflective design.

Due to the complexities of reflexivity and positionality, it is important for the researcher to acknowledge and state any personal or professional relationships and biases. Maher and Tetreault (1994) defined *positionality* as how people are identified in a social and political context. Positionality includes race, gender, class, sexuality, education and any other defining category (St. Louis & Calabrese Barton, 2002). I position myself as both a Black woman and a Clinical Social Worker. I reside in New Haven County. I also own a clinical private practice in Fairfield County. Lastly, I once engaged in voluntary mental health services. To facilitate reflectivity and add transparency I used a self-reflective journal. Self-reflective journals document the researcher's bias, experiences and presuppositions throughout the research journey (Ortlipp, 2009). There is no conflict of interest of connection with the participants or research site.

Bracketing was used to lessen the effects of preconceptions tainting the research data and process (Tufford & Newman, 2010). There is not one, uniform definition for bracketing. For this study, I adopted the definition for bracketing given by Starks and Trinidad (2007). Bracketing is a self-reflective process that sets aside prior knowledge in an attempt to keep an open mind and remain objective (Starks & Trinidad, 2007). There are several ways to bracket, including writing memos, engaging in interviews with others outside of the study, and reflective journaling (Tufford & Newman, 2010). A combination of reflective journaling and writing memos was used throughout this study.

Methodology

This was a qualitative, hermeneutic phenomenological study. The criteria to participate in this study was (a) a woman who identifies as Black, (b) is 18 years of age or older, (c) who has continuously and voluntarily used mental health services for at least three months, (d) and who has been discharged from mental health services. Participants were recruited by flyers distributed in community locations such as the library, coffee shops, and other businesses in Fairfield and New Haven Counties in Connecticut.

Sampling Strategy

The sampling strategy used in this study was purposive sampling. Purposive sampling gives the researcher greater control over the selection process as opposed to quantitative research (Barbour, 2001). The two types of purposive sampling that I used are snowball and criterion. Criterion sampling is used to recruit participants that meet specific requirements (Black women who voluntarily engage in mental health services). Due to the low participation rate of Black women in research, snowball sampling was

used (see Scharff et al., 2015). Snowball sampling occurs when participants are asked to recommend additional participants for a study. The first participant was recruited through local advertising. Snowball sampling was used therefore after.

Potential participants contacted the researcher for a brief prestudy interview. During the prestudy interview, I administered a demographic survey and inquired about the participant's utilization of mental health services. There is not a method to cross-reference race, ethnicity, and use of mental health services. Race, ethnicity, and mental health services was noted as self-reported. Once the information is vetted, the participant was selected to enter the study.

It is difficult to determine the sample size for qualitative studies. Onwuenegbuzie and Leech (2007) noted that sample sizes for qualitative studies should not be too large where data cannot be extracted; however, it should not be too small where saturation cannot be accomplished. The sample size for a phenomenological study is between 3-10 participants (Starks & Trinidad, 2007).

In a phenomenological study on African Americans overcoming barriers to therapy, Hall and Sandberg (2012) used a sample size of six (which also included men). Marshall (1996) noted that an appropriate sample size is one that properly and adequately answers the research question. The sample size for this study was six. Saturation is achieved when no new information arises from the data (see Saunders, Sim, Kingstone, et al., 2018).

Instrumentation

There are several tools that can be used to collect data in qualitative studies. The tools used for data collection in qualitative studies are interviews, focus groups, journals and open-ended questionnaires (Burkholder et al., 2016). Phenomenological studies analyze participants experiences; thus, direct quotes are needed from the participants. This study used a two-prong data collection approach: individual face-to-face interviews and a demographic questionnaire.

There are two categories of interviews, individual and group (Burkholder et al., 2016). The most commonly used data collection method for phenomenological studies are semi-structured interviews (Burkholder et al., 2016). Semi-structured interviews have a preconstructed interview guide; however, it also allows for probing and additional dialogue to gain a deeper understanding of the information.

I developed the interview questions by wanting to know a deeper understanding of the lived experiences of Black women's experience with mental health services. The literature review further helped me to develop the interview questions. In the literature review, I reviewed research on why Black women do not attend therapy, the stigma associated with mental health in Black communities, cultural and historical views on Black women and therapy; however, there is a gap in the literature regarding the lived experiences of Black women who voluntarily engage in mental health services. The interview questions were designed from a need to fill the gap in literature. The interview questions that I developed unearth the hidden experiences and probe to gather rich data.

Jacob and Furgerson (2012) noted several tips for conducting interviews. The authors note starting with the basics (name, where they grew up, etc.) and asking open-ended questions. Open-ended questions allow for quality data and follow up questions. According to Patton (2015), interviews are used to enter another person's perspective. The author further states we interview to gather stories. For these reasons, in-depth interviews are the most effective data collection tool for this study. The goal of this approach was to gather stories and perspectives about the use of mental health services.

Data Collection

The individual, face-to-face interviews lasted 60-90 minutes. The participant was able to choose the location or opt for a virtual meeting via GoToMeeting. GoToMeeting is an online secure video conferencing platform. The participants were given confidential identification numbers. All interviews were recorded for transcription. Before the start of the interview, I obtained informed consent. Participants were reminded that consent can be withdrawn at any time.

The first stage of the interview was the demographic questionnaire. The demographic questionnaire collects information on mental health background (i.e., length of time in mental health services, discharge date, how many times has the participant engaged in mental health services). The demographic questionnaire also included inquiries about personal information such as age, marital status, profession, race/ethnicity, socioeconomic status.

After the completion of the demographic questionnaire, the participant was asked 11 open-ended questions about access to mental health services, utilization of services, barriers to services, and outcomes of mental health services.

1. What did you know about mental health services before engaging in services?
2. What were your experiences, earlier in life, with mental health services before engaging in services?
3. What was your thought process regarding the pros and cons regarding the use of mental health services before engaging in services?
4. Have your thoughts changed about mental health services changed over time and throughout your life? If so, what are your thoughts about mental health services now?
5. Tell me about your experience engaging with mental health services.
6. Have you ever engaged in mental health services before this last time? If so, what was the outcome? What were your experiences?
7. What caused you to seek out mental health services?
8. Were there aspects of your daily life that inhibited or promoted the use of services?
9. Has engaging in mental health services changed your daily lifestyle? If so, can you tell me how?
10. Reflecting back the pros and cons of using mental health services what are your final thoughts about the experiences and processes of using the services?
11. Is there anything else you would like to share with me?

All digital files were stored in a password- protected external hard drive. Researcher notes and all written communication were stored in a locked file cabinet in a locked office. All backup copies of written and digital files were kept in a separate, locked location. The files will now be kept in a secured location for 5 years and then destroyed: written communication will be shredded, and digital data will be deleted from the hard drive.

Data Analysis Plan

Data analysis in qualitative research is a multistage and complex process. There are several approaches to data analysis in phenomenological studies. The Colaizzi (1978) phenomenological method was used to analyze the data; it has been used in phenomenological studies to increase trustworthiness and rigor (Edward & Welsh, 2011). The Colaizzi method has eight steps: (a) transcribing all subject's descriptions (b) extracting significant statements (c) creating formulated meaning (d) aggregating formulated meanings into themes or clusters (e) developing an exhaustive description or narrative of the participants experience (f) researcher interpretative analysis of symbolic representations (g) return to participants for validation (Edward & Welsh, 2011).

Once the information was collected, it was organized and analyzed using MAXQDA software, a qualitative and mixed-method data analysis software recommended phenomenological studies (Sohn, 2017). Data analysis took place throughout the study by using member checking. Member checking is the process in which the participants can review the collected data to ensure accuracy (Shenton, 2014).

Trustworthiness

In this study, I address the trustworthiness of the data and results. Four criteria should be considered when addressing the trustworthiness of a study (Shenton, 2004). The requirements are credibility, transferability, dependability, and confirmability.

Credibility

There are multiple ways by which I ensured credibility in this study. Mills, Durepos, and Wiebe (2010) defined *credibility* as the degree to which the data is accurate, aligned with the participants intended meaning and plausible. The results of a research study are deemed credible due to the methods that are used to collect the data (Shenton, 2014). In-depth interviews and demographic questionnaires are data collection tools that are widely used in qualitative research.

In addition, member checking was used to ensure credibility. Member checking can take place at any point in the study (Shenton, 2014). Participants was asked to review the written transcripts to ensure that they reflect their intended articulation of the phenomena. Each participant was asked the same interview questions and given the opportunity to review the data and interpretations. Member checking was used to verify the accuracy of the data.

Transferability

While the results of this study are geared towards a particular population, this does not mean that results will apply to all similar settings. Transferability in qualitative research must be understood in the context in which the study takes place. *Transferability* refers to how the study can be transferred or applied to other context, settings, and

situations (Shenton, 2014). The goal of qualitative research is not to generalize, but to be transferable. Transferability may be possible by providing thick descriptions of data and using a variety of participants. Ultimately, it is at the discretion of future researchers to determine the transferability of these results.

Dependability

Dependability in qualitative research aids in achieving trustworthiness. Dependable strategies use techniques, methods or strategies that can be replicated in a similar study that would lead to parallel outcomes (Shenton, 2004). The research design should be a model for similar future studies (Shenton, 2004). Also, dependable strategies, such as in-depth interviews and Colaizzi data analysis method, as well as, the previously mentioned purposive sampling and member checking, is used during the study.

Confirmability

The concept of *confirmability* in qualitative research is described as the degree to which the results can be confirmed by others (Shenton,2014). The data should reflect the experiences of the participants, not the presumptions or experiences of the researcher (Shenton, 2014). Thus, confirmability confirms the data using various methods to test the trustworthiness. Throughout the research process, reflexivity was used as a tool to increase objectivity. Reflexivity is the act of being aware and systematically controlling my biases, assumptions, and position (Reflectivity, 2014). In this study I addressed reflexivity by using a reflexive journal throughout the research process.

Ethical Procedures

Ethical mindfulness and considerations must be acknowledged throughout the research study (Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014). In an effort to ensure ethical procedures, I have incorporated best practices and followed appropriate measures for handling participants and confidential information. I gained Walden University's IRB approval prior to participant selection, contact, or data collection (Approval No. 12-05-19-0682533). Each participant was given the right to participate, end participation at any time, or to refuse to answer individual questions if they so choose. Consent can be withdrawn at any time. Participants were given identification codes (pseudonyms) to secure confidentiality in the data presented in the final study. Interviews were recorded and stored securely. All digital files were stored in a password protected external hard drive. Researcher notes and all written communication were stored in a locked file cabinet in a locked office. All backup copies of written and digital files are kept in a separate locked location. All data will be kept for 5 years after the final study is approved, upon which all data and back up data will be destroyed.

Summary

In this chapter, I reviewed the methodology, research design, participant recruitment strategies, data analysis plan, trustworthiness, and ethical concerns of the research study. Additionally, the social change impact was discussed. Chapter 4 will discuss the results of this study.

Chapter 4: Results

Introduction

The purpose of this phenomenological study was to explore the lived experiences of Black women who voluntarily engage in mental health services. In this study, I addressed the problem of their low engagement with mental health services. I sought to understand the experiences and outcomes of Black women who use mental health services, to understand what experiences and other factors led to voluntary treatment, coping skills, and other therapeutic methods used before seeking mental health services. Because completing treatment is a continual challenge, I enrolled only those who completed treatment (see Jones & Sheftall, 2015).

In this chapter, I present the findings that emerged as a result of the methods and procedures described in Chapter 3. One research question was presented for analysis: What are the lived experiences of Black women who voluntarily engage in mental health services? I will also provide detailed information on the setting of the interviews, demographics of the participants, data collection and data analysis procedures, evidence of trustworthiness, and the results of the research.

Setting

Data for this study were collected from participants in Fairfield and New Haven counties in Connecticut. Face-to-face interviews were used. Participants had to meet four requirements: a woman (a) who identifies as Black, (b) is 18 years of age or older, (c) continuously and voluntarily used mental health services for at least 3 months, and (d)

was discharged from mental health services. Flyers were distributed in community locations such as libraries, coffee shops, and other businesses in Fairfield and New Haven counties. Participants initiated contact with the researcher.

At the point of contact, the participant was asked the prestudy questions to verify that she met the study requirements. The background of the study was explained, and participants were given the informed consent form. The participants were allowed to ask questions and reminded that they could withdraw at any time. Prior to the interview, the participants were asked to complete a four-question demographic survey (see Table 1).

Six interviews were collected in total. Marshall (1996) noted that appropriate sample size is one that properly and adequately answers the research question, and saturation has been achieved. Saunders et al. (2018) explained saturation is achieved when no new information arises from the data. Saturation was achieved in the first six interviews due to the lack of new theme development and redundancy in the participant's responses.

Each face-to-face interview was completed at a convenient location of the participants choosing. Each interview lasted approximately 1 hour. All interviews were recorded, and notes taken to improve accuracy. No follow-up interviews were needed. Data were collected from December 11, 2019 to December 30, 2019.

Demographics

The participant population included six women who self-identified as Black, were between the ages of 35 and 62 years old, and who lived in Fairfield and New Haven counties in Connecticut.

Table 1

Demographic Outline of the Participants

Participant	Age	Education	Household composition	Professional or employment status
P1	35	Some college credit, no degree	Divorced	Out of work looking for work
P5	36	Professional degree	Divorced	Employed for wages
P4	43	Trade, technical/vocational training	Single, never married	Employed for wages
P6	47	Associate degree	Married	Employed for wages
P2	51	Master's degree	Married	Employed for wages and self-employed
P3	62	Some college credit, no degree	Engaged	Employed for wages

As shown in Table 1, two participants had some college but no degree, one had a professional degree, one had an Associate degree, one had a Master's degree, and one had trade, technical or vocational training. As for household composition, two participants were married, two divorced, one engaged and one single, never married. Regarding employment, five participants were employed for wages; one participant was out of work, looking for work. One participant was self-employed in addition to working for wages.

Data Collection

The purpose of this phenomenological study was to explore the lived experiences of Black women who voluntarily engage in mental health services. Data were collected using face-to-face interviews to explore the purpose of this study. An approved IRB interview guide was used as a data collection tool. Interviews were recorded with the participant's permission for transcription. The proposed maximum length of the interview

was 90 minutes. All interviews lasted between 45- 60 minutes. The variation of time was due to the elaboration of the participant's explanations and experiences. Seven women inquired about participating in the study. One potential participant was declined participation in the study due to not living in Fairfield or New Haven Counties. Six interviews were conducted from women who self-identified as Black and lived in Fairfield and New Haven counties. The interviews were held at a convenient location of the participants choosing. The participants were given confidential identification numbers. Before the start of the interview, I obtained informed consent. Participants were reminded that consent could be withdrawn at any time.

The first stage of the interview was the demographic questionnaire. After the completion of the demographic questionnaire, the participants were asked a series of open-ended questions using the IRB-approved interview guide. While multiple interviews were approved, if needed, clarity and depth were obtained in the initial interview. Member-checking was performed at the end of every session to ensure accuracy. Follow-up interviews were not required.

Interviews were recorded using a voice recorder. The notes and voice recorder are stored securely. All digital files are stored in a password-protected external hard drive. Researcher notes and all written communication are stored in a locked file cabinet in a locked office.

Data Analysis

Using the IRB approved question guide, I interviewed six women to gain an in-depth understanding of their experience and thought process regarding their therapeutic

process. The interview guide also helped to facilitate answers to the research question, what are the lived experiences of Black women who voluntarily engage in mental health services?

After completion of the interview process, I organized and transcribed the data using computer-assisted, qualitative and mixed-method data analysis software, MAXQDA. According to Sohn (2017), it is recommended for phenomenological studies. Member checking happened throughout, at the end of every interview, and as needed throughout the data analysis process. Member checking is the process in which the participants can review the collected data to ensure accuracy (Shenton, 2014).

Using MAXQDA, I was able to code, categorize, and identify themes for the data. Saldana (2016) defines a code as a single word or short phrase that symbolically assigns a summative, salient, essence capturing, and/or evocative attribute for a portion of language or-based or visual data. I analyzed the data for similarities, differences, frequency, and sequencing. Five deductive codes were taken into consideration at the start of data analysis. The deductive codes were identified through the conceptual framework, research literature, and the research question. The five codes were:

- access and use of mental health services,
- stigma and shame,
- cultural misunderstanding,
- race and culture, and
- StrongBlackWoman.

Seven inductive codes were identified during the analysis of the data. Inductive codes are based on observation and analysis from the data (Saldana, 2016). The inductive codes identified were:

- medication,
- freedom to choose,
- mental health,
- resistance,
- frustration,
- personal motivation, and
- coping skills.

Both the inductive and the deductive codes were grouped into what is known as categories. Categories are similar ideas, thoughts, or patterns explicitly conveyed in the data (Vaismoradi et al., 2016; Saldana, 2016). The categories derived from the data analysis process were:

- early in life experiences with mental illness or mental health services,
- reasons for engaging in mental health services,
- the process of accessing mental health services
- thoughts about mental health services over time, and
- outcomes of using mental health services.

After categorizing the codes and further analyzing and reviewing the data, several themes emerged. Vaismoradi et al. (2016) define themes as the "main product" of data analysis. Themes are the attributes, patterns, trends, and the essence of the data (Saldana,

2016; Morse, 2008). Themes describe the latent meaning of a participant's response. Themes answer the research question (Vaismoradi et al., 2016). Themes are discovered and interpreted through the data analysis process by the researcher. Several themes emerged that answered the research question of what are the lived experiences of Black women who voluntarily engage in mental health services? The themes that emerged were:

- engaging in mental health services is a last resort,
- marriage, children, and work-related issues are reasons for seeking out mental health services,
- overcoming stigma, stereotypes, and cultural myths is necessary for treatment,
- finding the right fit in a provider is a challenge, and
    - trying multiple times for the right fit (therapist)
- coping skills, empowerment, and self-efficacy are outcomes of engaging in mental health services.

Evidence of Trustworthiness

The requirements of trustworthiness in qualitative research are creditability, transferability, dependability, and confirmability (Shenton, 2014). Creditability, dependability, and transferability were ensured by using a trusted research method such as in-depth interviews and the Colaizzi's data analysis method. Additionally, participants were asked the same questions from the IRB approved interview guide and allowed to review their responses for accuracy prior to the conclusion of the interview. This method is called member checking. Confirmability was implemented using a reflexive journal

throughout the research process. Using a reflexive journal ensured that my biases, assumptions, and positions were controlled.

Results

During the data analysis process, I prepared, transcribed, and analyzed six face-to-face interviews. Using MAXDQA, I was able to identify five overarching themes that answered the research question: What are the lived experiences of Black women who voluntarily seek mental health services? The data were examined and reviewed multiple times to ensure it was sufficient to answer the research question. Mutual responses were arranged together. The results of the data analysis are presented in the form of five themes which are discussed in this section. The five themes and one subtheme were as follows:

- engaging in mental health services is a last resort,
- marriage, children, and work-related issues are reasons for seeking out mental health services,
- overcoming stigma, stereotypes, and cultural myths is necessary for treatment,
- finding the right fit in a provider is a challenge, and
    - trying multiple times for the right fit (therapist)
- coping skills, empowerment, and self-efficacy are outcomes of engaging in mental health services.

Upon completion of the data analysis, it was evident that the results of the interviews are consistent with the research cited. Overall, the Black women interviewed had a difficult time accessing and engaging in mental health services. Many of the

responses expounded on the desire for mental health services, simultaneously, describing the barriers to receiving the needed services.

Engaging in Mental Health Services is a Last Resort

The first identified theme emphasized the participant's experience with engaging in mental health services. The shared experience of the participants is their use of mental health services as a last resort. The participants described using other ways of coping, such as informal supports like church, family, and friends, before seeking out mental health services. Another coping that was identified was promiscuity. Additional reasons include stigma, cultural myths, and the fear of being misunderstood. These factors are discussed in detail later.

When asked what inhibited the use of mental health services, the following responses were given: P1 stated:

> I look at it like, Ma'am, you have two sons. You are 21, and your ways aren't working. Because clearly, you have not left this bed for eight months, and your young children are figuring out how to take care of themselves as babies. You can't even bring them across the street to school; you might want to go talk to somebody because at this point. It's beyond my control.

P1 further commented, “I knew that there were services and things available I just didn't think they apply to me.” Participant 3 remarked:

> We were in a very toxic relationship; there was not only emotional abuse; there was physical abuse. So, umm, that was more so it and him not wanting to try, just

kind of just like really pissed me off, and just said look, okay, I'm done. Okay, so that's when it really kind of started the counseling and stuff for me.

P4 commented when asked what caused her to seek out services, stated: "I done did everything else, and everything else did not work." P5 noted it took ten years before engaging in mental health services. P5 commented the delay in seeking services was due to "my attitude was that it was, it was a job for those people." Even after delaying engagement for ten years, P5 commented, "even when I engaged in services. I was still like this is a job, but maybe it can help my marriage."

After speaking with the participants, it is clear that engaging in mental health services was the last resort for many (five out of the six participants). Other methods used were social supports such as family and friends and "pushing through." Pushing through was explained as being a StrongBlackWoman; being able to handle anything that comes at you, and not complaining. These findings are aligned with the literature regarding why Black women do not seek out professional mental health services, and when they do, it is a last resort. It can be concluded that the delay in engaging in mental health services is due to social and cultural norms and stereotypes regarding mental health services and the stigma associated with not being able to handle all of your problems. At some point the participants, tried to follow the cultural norms and hid or shoulder their struggles until it became too much too bear. Additionally, the participants were aware of the services available; however, did not think the services were for them which also caused delay in engaging. The delay is seeking services is an example of the concept, John Henryism.

John Henryism is explained in Chapter 2 as an active coping or high effort coping. This perception is visible in the experiences of the participants.

Overcoming Stigma, Stereotypes, and Cultural Myths is Necessary for Treatment

A common theme arose during the interview process surrounding stigma, stereotypes, and cultural myths. Each participant dealt with overcoming these barriers in their way. Such barriers identified were being called or feeling like they are crazy, having been taken out of a leadership position at church due to seeking mental health services, not praying hard enough, and not being strong enough. When asked about the barriers to seeking mental health services, P2 commented: “And so for me, it was always like, uh, no. That's for crazy people, and I am not crazy. I am mad as hell at my family.” P2 also stated:

> I would say a majority of the African American families I know, say, what happens at home stays at home. If we talk about it, it is something that seems to be pointing fingers at certain people that did something that they should not have done. It is like hush, just be quiet, don't talk about this, don't talk about that, and we'll just move on and get over it and deal with it. So that was my initial thought process, is that you're not supposed to talk about certain things. And it's not okay to talk about how you feel about anything, you just have to be a strong Black woman, and deal with it. Right! Auntie was strong, grandmama strong, you will have to be too.

P4 shared, "I felt that if you have to talk to somebody, there's something seriously wrong with you and that you should be able to figure stuff out for yourself and being judged." P3 responded:

> You know, because once you start going to see a therapist, everybody thinks you're crazy. You know, so just having that stipulated on me was like, no, because that's not who I was. And I'm crazy. Yeah, but not like that. So, it was all of those things that made me, you know, kind of question, do I really need this.

P6 commented:

> I felt like it was, there was a certain type of taboo to it (mental health services) in our community. It was one of those things where they said only white people did. But I wanted to go anyway I felt like my need to go was greater than what that notion was.

All responses dealt with facing some type of internal or external cognitive barrier; however, each overcoming the barriers to engage in mental health services. The participants overcame the barriers and faced being stigmatized and stereotyped due to the result of other methods of coping being ineffective or providing short term relief. Each participant had a motivating factor that enforced their desire to try mental health services.

The motivating factors were children, wanting a better life, and being dissatisfied with their current emotional status. The findings of this data are congruent with the known research on stigma, cultural myths, and stereotypes in relationship to Black women who seek out mental health services. It is well documented that stigma, cultural myths, and stereotypes contribute to the low engagement of Black women in mental

health services (Campbell & Mowbray, 2016; Awosan, Sanberg, and Hall, 2011; Allen et al., 2010). Stigma can be seen in the form of distancing, isolating, labeling, talking down, discrimination, ridiculing, and ostracizing. As stated in chapter 2, culture has a significant impact on decision making, shaping beliefs, communication, values, laws, and rules (Cole et al., 2009). It is concluded that the same barriers noted in the cited research are prevalent in the experiences of the participants. While the social and cultural barriers have not changed it can be concluded that the participants were able to manage or remove the barriers to seek the services they needed. This theme illustrates the importance of *herstory* as posited in the conceptual framework of Black Womanist Thought. It is important for Black women to shape and narrate their experiences (Howard-Hamilton, 2003), especially the experiences while engaging in mental health services.

Marriage, Children and Work-Related Problems are Reasons for Seeking Out Mental Health Services

Concerning the question of what caused the participants to seek out mental health services, three topics were identified: Marriage, children, and work-related problems. Three women referenced marriage, two women, referenced wanting to be better for their children or grandchildren, one woman referenced having work-related problems. P6 commented, "I was married, and my husband at the time told me, just out of the blue, that he didn't want to be married anymore, he didn't want me or want anything to do with the marriage." P6 went on to explain how her mom and dad had a tumultuous relationship. Ultimately ending with her mom having a "nervous breakdown." P6 further commented,

"my mom was very bitter, very emotional and clinically depressed, and I knew that I didn't want that. So, I knew that I needed to seek help for myself right away."

P4 shared work-related issues, “taking on other people’s problems at work” as her reason for seeking therapy. P2 commented:

> I got to the point where I was like, you know, what this is a problem, and I need to get help for this problem because my first granddaughter was born. I was like, I want to be able to be present with her, and with the kids. I can't keep going back and forth with this emotional rollercoaster feeling, and so it was like, I had to go ahead and figure out how to solve all the problems and get on a better path.

Research cites work-issues, life transitions, and personal relationships as reasons to seek mental health services. The data not only aligned with the research, but it also confirmed what I supposed. The participants seemed to be surprised after engaging in mental health services to find out they were not “crazy.” The normalization of their stress and high anxiety situations did not equate to a mental illness. Attending therapy normalized and reinforced their feelings of being overwhelmed, while concurrently dispelling the myth that one has to be “crazy” to engage in mental health services. Overall, despite Black women having a higher prevalence of ADHD, depression, and PTSD (U.S. Department of Health and Human Services Maternal and Child Health Bureau, 2013) the study participants did not have any serious mental illnesses. Most of the participants attribute busy lives, work schedules, and domestic responsibilities as stressors. This is congruent with the findings from Jones and Guy-Sheftall (2015).

Finding the Right Fit in a Provider is a Challenge

Every participant mentioned having more than one therapist and having to change therapist before finding the right fit in a provider. The participants describe the right fit as someone compatible and understanding, someone who can relate and has a good rapport with the client. The right fit also includes the actual therapeutic environment. Furthermore, the right fit is a "safe place." Research cites cultural competency, race, and understanding the unique concerns of Black women as essential factors for finding the right therapist. P2 shared her account of finding the right fit:

> She [the therapist] was very refreshing because she allowed me to be me and for it to be okay to be me and express myself the way I needed to express myself if I wanted to cry. It was always frowned upon. When I cried [outside of therapy], it was like I was weak. So, it was like, okay [sigh of relief]; finally, I can just sit here and just do the ugly cry. It's okay. She just gave me a tissue. She was like; you can just stay here and cry the whole session.

It could be concluded that the right fit is both environmental and personal. It is well documented in Chapter 2 that two barriers for Black women who wish to engage in mental health treatment are poor quality of care and cultural matching (Ward & Heidrich, 2009). It is essential to find someone whom one can connect with; however, a safe and welcoming environment is also important. The participants' experiences align with the research, confirming the necessity for quality of care and someone who understands them. Unexpectedly, the therapist did not have to be of the same ethnic background.

Trying multiple times for the right fit. Each participant has had more than one therapist. Some due to the right fit, therapist leaving agencies, others due to starting and

stopping therapy at different times in their life. Four out of the six participant's changed therapist two or more times due to not feeling comfortable, being misdiagnosed, or misunderstood. P2 attributed her experience with finding a good therapist to being educated. P2 commented:

> Because I know when I was a single mother, and I was on the state [public assistance] and all these other things and trying to get help for the kids with the issues and then them [the agency employees] looking at me saying, well, you got your Master's degree. Like somebody that's educated can't have problems and need help.

P4 shared her experience with mental health services, stating, "it's kind of hard to find therapists, especially if you be trying to find African American therapists." P4 expounded on her experience, stating it was difficult for her to find the right fit for several reasons: time, insurance, and the right person. P4 had recently withdrawn from treatment due to it being a "mismatch." P4 was reluctant to engage in therapy again after one failed attempt; however, she had recently decided she wanted to try again. P5 comments, "I went to three or four within like a month or two, and then I just stopped for a couple of months."

Each participant had an interesting experience with mental health services. It can be concluded from the data that engaging in mental health services is a journey with multiple attempts. It is not often a one-step process. This concept aligns with the research. Research indicates some certain particularities and concerns need to be taken into consideration when treating Black women. This is evident in this data. The variance

between the data and the research lies in the prompting for Black women to seek out Black mental health providers. While each participant acknowledged that having a Black mental health provider might be beneficial, only two participants intentionally sought out a Black mental health provider. Most participants solely searched for someone who could understand them, regardless of race. Research suggests that Black women terminate early from mental health services due to the care provided by the practitioner. This pattern is evident in the data collected in this study. The cited research also supports the theme of engaging in mental health services multiple times.

Coping Skills, Empowerment, and Self-Efficacy Are Outcomes of Engaging in Mental Health Services

There were three significant outcomes identified as a result of engaging in mental health services. Coping skills, empowerment, and self-efficacy were identified as significant outcomes. Each participant, regardless of the number of tries with multiple therapists, identified new skills from engaging in mental health services.

Coping skills were identified as the first significant category. Skills such as resilience, time management, boundaries, patience, releasing some stuff, readjusting, meditating, co-parenting, and "falling back" were grouped under the category of coping skills. When asked has engaging in mental health services changed your daily life, P4 responded, "She kind of taught me just not to tolerate stuff. She gave me certain tools, saying no and not feeling guilty, and manage my time." P4 also commented that going to therapy helped her "release some stuff." P5 commented, "she actually helped me to let go and co-parent, and they gave me techniques for meditating, you know, breathing

exercises and stress relief." P3 responded, "I've learned to navigate and alleviate stress, and to let things go."

The second major category was empowerment and self-efficacy. Self-love, advocacy, and purpose were grouped under the empowerment and self-efficacy category. P2 commented, "she empowered me to be able to figure out things on my own as well as my faith in God. She allowed me to work out my problem, even though she sat and listened to me, she allowed me to work out my problem." P2 further comments that an outcome of engaging in mental health services was starting her own business. Therapy taught her to believe in her power to change her situation. P3 stated, "she has empowered to be an advocate." P3 now enjoys speaking to others about her life experiences. P3 also attributes finding purpose as an outcome of engaging in mental health services.

According to the American Psychological Association (2019) benefits of psychotherapy include improvement in emotions and behaviors and positive changes in the body. These findings echo the literature regarding the outcomes of mental health services. It can be concluded that if one actively participates in the emotional wellness process, positive outcomes and a healthier lifestyle can be achieved. The consensus of the participants is engaging in mental health services has proven to be beneficial, and each participant is willing to return to services should the need arise. It can be concluded that voluntarily engaging in mental health services has greater benefits versus involuntary, crisis engagement.

Overall, the participants did not know what to expect from engaging in mental health services. However, most of the women report learning new skills and making changes in their lives in order to prevent future dysfunctional cycles from occurring.

Overall Results Summary

Six face to face interviews with Black women between the ages of 35-62 years old was conducted in Fairfield and New Haven Counties in Connecticut. Each participant gave in-depth information regarding their lived experience with engaging in mental health services. The information provided answered the research question, what are the lived experiences of Black women who voluntarily engage in mental health services? The results of the study were found to be congruent with the research cited.

A majority of the participants engaged in mental health services as a last resort. Many participants tried other options such as informal supports such as family and friends, social groups such as church and other communities, and spiritual practice such as prayer before seeking mental health services. Two participants delayed engagement due to childhood experiences with mental health services. One participant stated despite knowing the available mental health services; she felt they were only for white people. Consequently, suffering longer than they needed to.

The participants also mentioned having to try more than one therapist to find the right fit. Each participant had more than one therapist, one participant had tried up to four over a few months. Being comfortable with the therapist and environment was defined as the right fit. Each participant mentioned having to feel comfortable and safe to begin the

process. Two participants said, feeling judged or misunderstood. This feeling resulted in the termination of the therapeutic relationship.

The participants were also clear on why they continued to seek mental health services after failed connections. Each participant had a deep desire to change their way of life, most stating "nothing else worked." The deciding factor for most of the women were their children and wanting a better life. This desire fueled the efforts to continue to seek out mental health services time and time again.

Research cites the need for Black women to received culturally competent and aware mental health services. Using the lens of intersectionality, it is vital to understand a Black woman through multiple contexts, the most important is being Black and a woman. This research lends itself to the idea that Black women should seek out Black therapists. However, in this study, five out of the six participants did not have a Black woman as a therapist. I must note that all the participants did have female therapists, but five out of the six of the therapists were not Black. Additionally, the participants did agree that race matters; however, the connection to the person mattered most.

Summary

In this chapter, I reviewed the setting, demographics, data collection strategy, data analysis plan, evidence of trustworthiness, and the results of six face-to-face, in-depth interviews conducted in Fairfield and New Haven Counties in Connecticut.

In Chapter 5, I will discuss the interpretation of the findings, limitations of the study, recommendations, and implications of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this phenomenological study was to explore the lived experiences of Black women who voluntarily engage in mental health services. In this study, I addressed the problem of their low engagement with mental health services. I sought to understand the experiences and outcomes of Black women who use mental health services, to understand what experiences and other factors led to voluntary treatment, to coping skills, and to other therapeutic methods used before seeking mental health services. Because completing treatment is a continual challenge, I enrolled only those who completed treatment (see Jones & Sheftall, 2015).

I used purposive sampling in this study and was contacted by candidates for a brief prestudy interview, where I administered a demographic survey and inquired about their use of mental health services. The data were collected via individual, face-to-face interviews, lasting approximately 60 minutes. Participants choose the location. Each was asked a series of open-ended questions about access to mental health services, use of services, barriers to services, and outcomes of services.

Five themes emerged that answered the research question: What are the lived experiences of Black women who voluntarily engage in mental health services?

- Engaging in mental health services is a last resort
- Marriage, children, and work-related issues are reasons for seeking out mental health services
- Overcoming stigma, stereotypes, and cultural myths is necessary for treatment

- Finding the right fit in a provider is a challenge, and
    - Trying multiple times for the right fit (therapist)
- Coping skills, empowerment, and self-efficacy are outcomes of engaging in mental health services

One of the key findings of the study was that mental health services were used as a last resort. Five out of six participants delayed seeking services for various reasons. When the participants did engage, it took numerous tries before they found the right fit. One can conclude that determination and the will to find relief in their situations were motivating factors to endure the process of seeking mental health services. In addition, each participant had to overcome stigma, stereotypes, and cultural myths prior and in some cases during the therapeutic process. Ultimately, the participants found therapy to be helpful. In this chapter, I will discuss the interpretation of the findings, limitations of the study, recommendations, implications of the study, and the conclusion.

Interpretation of the Findings

The discussion presented provides insight into the research question, what are the lived experiences of Black women who voluntarily engage in mental health services. A summary and interpretation of the findings will be examined in correlation to the research cited in Chapter 2. Five themes emerged in the data analysis process. The themes were: engaging in mental health services is a last resort, marriage, children and work-related issues are reasons for seeking out mental health services, overcoming stigma, stereotypes, and cultural myths is necessary for treatment, finding the right fit in a provider is a challenge (trying multiple times for the right fit (therapist), and coping

skills, empowerment, and self-efficacy are outcomes of engaging in mental health services. Every theme identified echoed the results of similar studies conducted on Black women and mental health.

The barriers and reasons why Black women do not seek out mental health services are thoroughly researched. In Chapter 2, I discussed, in detail, the extensive research and data on why Black women do not seek out mental health services. In this section, I will elaborate on the conclusions from the present study that confirm, disconfirm, or extend the knowledge in Chapter 2.

Overall, the findings from this study mirror the research noted in Chapter 2. The barriers of stigma, shame, race and culture, StrongBlackWoman, and cultural misunderstanding were all topics mentioned by the participants (Melissa Harris-Lacewell, 2001; Cheryl Wood-Giscombe et al., 2016; Bronder et al., 2014; Harrington et al., 2010; Cheryl Woods-Giscombe, 2010; Donovan & West, 2015; Watson & Hunter, 2016; Ward & Heidrich, 2009; Awosan, Sandberg & Hall, 2011; Allen et al., 2010; Campbell & Mowbray, 2016). All participants had to overcome shame and stigma to seek mental health services. P2 shared experiencing stigma such as finger pointing and being "hushed." P5 also shared her experience with stigma, stating, "people thought I was crazy for talking about my everyday problems." While all the barriers were present for each participant, their current situation became too much to bear. The emotional and physical weight of their stressors overshadowed the historical and cultural traditions and myths about mental health services.

Moreover, each participant dealt with a version of StrongBlackWoman syndrome. P2 describes her StrongBlackWoman experience as “my initial thought process is that you're not supposed to talk about certain things. And it's not okay to talk about how you feel about anything, you just have to be a strong Black woman.” P2 further explained the generational expectation of being a StrongBlackWoman stating, “Auntie was strong, grandmama strong, you will have to be too.” P5 commented, “I was like the typical strong woman who just went to work and went to school and then I raised my kids, and I just moved.” The theme of doing versus feeling was evident in the responses of the participants.

Each participant had unhealthy coping skills before engaging in mental health services. P4 explains how she compared herself to people she worked with. P4 stated, “I was thinking about them [co-workers] when I wasn’t supposed to be thinking about it [co-worker’s problems] and it was coming into my relationships.” P3 reported self-medicating using drugs to cope and remaining in an emotionally and physically abusive marriage prior to engaging in mental health services.

Furthermore, most of the women employed the use of informal support systems; however, finding that additional support was needed, soon resulting in professional services. Church, family, friends, and social networks were used as a first response to being overwhelmed. P1 clarified having family and friends did not equate to having support. P1stated “support is so interesting to me. Um, you see in that dark period, I don't think there was anyone there that was beneficial.” P4 referenced needing additional support outside of your friends. “I feel like I think everybody needs to talk and not just

your friends because your friends can give you their perception of what they've been through." Participants were in agreement in needing additional support outside of informal support systems, thus, engaging in mental health services as a last resort.

In addition, each participant engaged in a cognitive process which initiated the progression to overcome the internalization of stigma, cultural, and social norms, which had previously been barriers to treatment. Before the participants made the initial contact with a mental health service provider there was a conscious decision to seek services outside of what is socially accepted. Several participants noted reaching their "tipping point" and "trying everything else" prior to making the decision to seek out mental health services. In short, there was an internal or cognitive process that proceeded the external behavior of engaging in mental health services.

The consensus for seeking out mental health services was due to marriage, children, and work-related issues. P2 stated seeking out mental health services because she was expecting her first grandchild. P4 reported work-related problems as her reason for seeking out mental health services. P4 stated, "I was taking co-workers problems home, it all became too much." While previous literature does not explicitly outline specific causes for treatment, researchers have highlighted characteristics of Black women who struggle with StrongBlackwoman syndrome: a Black woman who is strong (physically and emotionally), independent, a care-taker, tenacious, self-efficacious, self-sacrificing, self-contained, and resilient (Bronder et al., 2014; Donovan & West, 2015; Stanton et al., 2017; Watson & Hunter, 2016);Woods-Giscombe, 2010). These perceived attributes deter Black women from seeking out mental health services (Melissa Harris-

Lacewell, 2001; Cheryl Wood-Giscombe et al., 2016; Bronder et al., 2014; Harrington et al., 2010Cheryl Woods-Giscombe, 2010; Donovan & West, 2015; Watson & Hunter, 2016). However, the participants in this study all indicated feeling like a StrongBlackWoman who needed help.

Overall, everyday life struggles and situations prompted the participants to seek out mental health services, not a mental illness or being crazy, as their cultural myths would have them to believe. Cultural myths are passed down from generation to generation. Cultural myths are a deterrent in the Black community against Blacks trusting the medical system, inclusive of mental health services (Brown & Keith, 2003). This key finding is important to note because it normalizes the use of mental health services while simultaneously dispelling a social and cultural myth in the Black community. Normalizing the use of mental health services due to everyday life struggles removes the stigma, a known barrier, associated with mental health services. Thus, increase the usage of mental health services among Black women.

This study also confirms the research on misdiagnosis presented in Chapter 2. A barrier to engagement and treatment for Black women in mental health services is misdiagnosed (Sosulski & Woodward, 2013; Neal-Barnett & Crowther, 2000; Ward & Heidrich, 2009; Awosan, Sandberg & Hall, 2011). Two of the six participants in this study were misdiagnosed early on in their journey into mental health treatment. P1 stated, after being misdiagnosed and hospitalized, "I had to prove that I was not crazy and did not belong in the hospital." P1 goes on to explain how she could not let this experience deter her from getting the help she desperately needed. P2 commented on being

misdiagnosed, "they tried to make my symptoms fit into a neat little box, each time they (doctors and mental health providers) guessed, it was not right." She, too, continued until she found someone who could help her.

This study's participants echo and confirm the existing research and knowledge, while also providing a counter-narrative to the literature. Much of the research to date has centered on the barriers and negative experiences of Black women in mental health (see Jones & Guy-Sheftall, 2015; McNair, 1996; Ward, Clark & Heidrich, 2009). This study explored the experiences of Black women *who do* access mental health services, understanding what opportunities, motivations, and experiences, over and above financial or cultural barriers, enabled them to voluntarily, successfully enroll and be treated. This study also extends the knowledge by adding the outcomes of enrollment. The main finding here that supports the literature is that, yes, Black women often do avoid seeking mental health services for the reasons already described in the literature; however, the key distinction from the literature is the positive outcome of engaging in mental health services. The literature cited in Chapter 2 explains the barriers to treatment and expounds on the negative experience encountered by Black women who have attempted engaging in mental health services; however, was unsuccessful for several reasons. This study illuminates the positive outcomes of engaging and remaining in mental health services. This study adds a counter-narrative to the literature adding a complete and balanced depiction of the Black women's experience with mental health services.

Limitations of the Study

There are several limitations to this study. The first limitation is the sample size. Six interviews were conducted and analyzed. Six interviews did demonstrate saturation and were enough to answer the research question thoroughly. The small sample size also aligns with phenomenological studies; however, six interviews may not be enough for future researchers to comfortably address transferability. Similarly, the scope of this study combines the intersection of race and gender. Participants must identify as Black and female to have been accepted in the study. Therefore, no interpretations can be made about males or other races.

Geographic location is also a limitation. The participants were located in urban communities in Fairfield and New Haven Counties. The results of this study may not be transferable to Black women from suburban or rural communities. In future research, widening the geographic parameters may prove to yield different results. Another limitation is the age group; the participant's ages range from 35-62 years old. This could be viewed as a limitation because the data does not reflect the experiences of those outside of this age group.

Lastly, in qualitative research, the researcher is a critical part of the research process. It is important to remember that a researcher's bias plays a role in the observation and analysis of the research (Burkholder et al., 2016). I am both a Black woman and a licensed clinical social worker. I reside in New Haven County. I also own a clinical private practice in Fairfield County. In addition, I once engaged in voluntary

mental health services. Understanding my positionality and the content and context of the study, I used a self-reflexive journal to facilitate reflexivity.

Recommendations

As described in the limitations section of the study, one recommendation is a larger, more diverse sample size. I explored the lived experiences of six Black women from Fairfield and New Haven Counties. Future studies should focus on exploring a larger sample size and Black women in other geographical locations. In addition, I focused on exploring the lived experiences of women from diverse ethnic backgrounds and races.

Further research should be conducted on the cognitive process of Black women who overcome internal barriers, such as shame and guilt, as well as cultural barriers, such as stigma and distrust of the medical system, to engage in mental health services. Moreover, further qualitative research on subject matters concerning Black women is recommended. Lindsey-Dennis (2015) noted the importance of using *herstory* to validate the stories of Black women. Participants noted numerous recommendations for mental health providers. The most common recommendation from the participants was access to mental health care—flexibility for scheduling treatment services. P5 stated feeling rushed and having to leave work to attend therapy sessions. P5 recommended having evening and weekend hours to help access mental health services for those who have to work. P2 recommended making the therapeutic space welcoming and less guarded by removing large desks as a barrier between the therapist and the client. Lastly, future research

endeavors should examine how race, stigma, and gender play a role in the decision to engage in mental health services among people of color, especially Black people.

Implications

The results of this study may have a significant impact on both research and social change. To date, though much research has been done on the access and utilization rates of Blacks and mental health services, exploring the barriers to each, no researchers have examined the lived experiences of Black women who voluntarily sought out and completed mental health treatment. This study contributes to the body of the existing research focused on Black women and mental health. Furthermore, this study contributes to existing research by adding a counter-narrative regarding Black women who voluntarily seek mental health services exploring their experiences with accessing, using, and completing treatment.

This study has potentially broad implications. The results of this study can directly impact psychologists, social works, mental health professionals, doctors, and Black women who are ambivalent about seeking mental health services. The lived experience of seeking, engaging, and completing mental health treatment can be a catalyst for change in Black women and women of all races and ethnicities in general, in similar situations. Mental health professionals alike can also understand and learn from the lived experiences of Black women who have sought to engage in mental health services. This study can give insight and guidance on how to better assist Black women who come from complicated backgrounds and have overcome barriers to seeking treatment. The experiences of the participants can hopefully facilitate changes in the

mental health system by providing clarity, cultural awareness, guidance on engagement, and shape policy. Ultimately, making the process easier when Black women decide to engage in mental health services.

Several participants gave valuable insight and feedback to assist others in deciding whether or not to seek out mental health services. P4 stated, "I think it's important to have somebody there that is not going to judge you, and you kinda have to research what kind of therapists because it is different types of therapists." One participant advised women not to just stop at the first therapist, P5 advised:

> Don't be afraid to ask for someone of the same ethnic background and your same gender. Don't be afraid to try one out, and then try another one out and then compare the two. I would say that's, in a nutshell, like don't be afraid. And go! Just go.

This study may affect social change by providing data from Black women that will assist in understanding the entire narrative of Black women who engage in mental health services. This study explored the problem of low utilization rates of mental health services among Black women, revealing positive experiences to increase voluntary mental health usage (see Copeland & Synder, 2011). The results of this study may provide insight and guidance for Black women who would like to seek mental health services but have encountered barriers, and potentially Blacks and women in general, as both see a low utilization rate with mental health services.

Conclusion

According to the U.S. Department of Health and Human Services Office of Minority Health (2017), African Americans and Blacks are 10% more likely to report having serious psychological distress than Non-Hispanic Whites. Roughly 18.6% of Blacks have a mental health condition (NAMI, 2018). Of the 18.6% of Blacks with mental health conditions, only 10.3% of Black *women* use mental health services (NAMI, 2018). Black women engage in mental health services at a lower rate than White women (American Psychiatric Association, 2017). Black women do not engage in mental health services due to social and cultural reasons. In addition to avoiding treatment for social and cultural reasons, unmet cultural, ethnic, and gender needs of Black women, they may delay treatment or withdraw early (Jones & Sheftall, 2015).

Much of the research to date focused on the barriers Black women face when accessing and using mental health services. This study focused on the lived experiences of Black women who overcame the barriers, engaged, and completed treatment. This study serves as a counter-narrative, giving a comprehensive view of the Black woman's experience in regard to engaging mental health services. This study solely focused on a group that is not often accounted for in research, Black women. This study is significant because it is a compilation of their stories, insights, and opinions.

Findings from this research mirror existing literature with respect to stigma and shame, StrongBlackWoman persona, cultural misunderstanding and, distrust of the medical system. This study further extends and adds the counter-narrative that expounds on the positive outcomes of engaging in mental health services after overcoming the

barriers to treatment. It is a consensus of the participants that one's desire to change their life has to be greater than the fear of being stigmatized or feelings of shame. This study is an attempt to prompt social change by decreasing stigma, eliminating shame, and increasing mental health access and use among Black women.

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Appendix A: Demographic Questionnaire

Age (or birth date)

Q. **Age:** What is your age?

Education

Q. **Education:** What is the highest degree or level of school you have completed? *If currently enrolled, highest degree received.*

- No schooling completed
- Nursery school to 8th grade
- Some high school, no diploma
- High school graduate, diploma or the equivalent (for example: GED)
- Some college credit, no degree
- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Master's degree
- Professional degree
- Doctorate degree

Household Composition

Q. **Marital Status:** What is your marital status?

- Single, never married
- Married or domestic partnership
- Widowed
- Divorced
- Separated

Professional or Employment Status

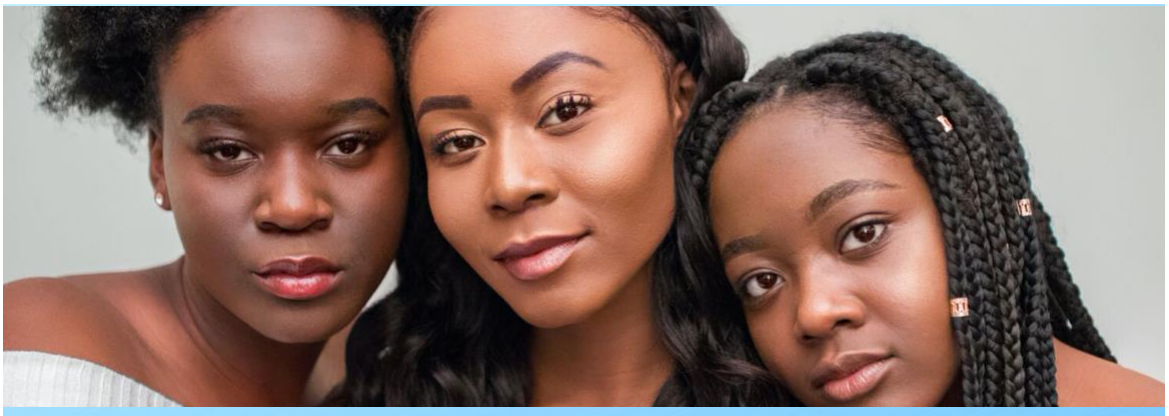
Q. **Employment Status:** Are you currently…?

- Employed for wages
- Self-employed
- Out of work and looking for work
- Out of work but not currently looking for work
- A homemaker
- A student
- Military
- Retired
- Unable to work

Appendix B: Interview Guide

1. What did you know about mental health services before engaging in services?
2. What were your experiences, earlier in life, with mental health services before engaging in services?
3. What was your thought process regarding the pros and cons regarding the use of mental health services before engaging in services?
4. Have your thoughts changed about mental health services changed over time and throughout your life? If so, what are your thoughts about mental health services now?
5. Tell me about your experience engaging with mental health services.
6. Have you ever engaged in mental health services before this last time? If so, what was the outcome? What were your experiences?
7. What caused you to seek out mental health services?
8. Were there aspects of your daily life that inhibited or promoted the use of services?
9. Has engaging in mental health services changed your daily lifestyle? If so, can you tell me how?
10. Reflecting back the pros and cons of using mental health services what are your final thoughts about the experiences and processes of using the services?
11. Is there anything else you would like to share with me?

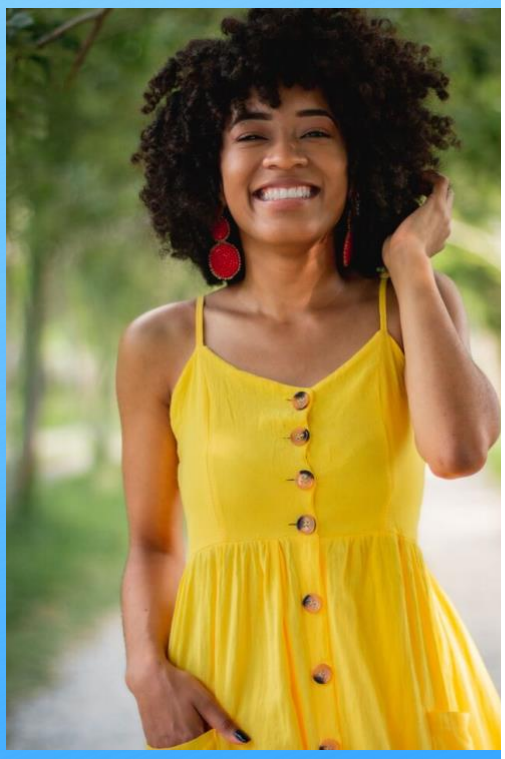
Appendix C: Study Flyer



Participants Needed

ARE YOU..

- A BLACK WOMAN?
- OVER 18 YEARS OLD?
- VOLUNTARILY USED MENTAL HEALTH SERVICES FOR AT LEAST THREE MONTHS?
- WHO HAS BEEN DISCHARGED FROM MENTAL HEALTH SERVICES?



You may be eligible to participate in this study.
Participants will be asked to attend 1-2 60-90 minute interviews.

This study will explore the lived experiences of Black women who voluntarily engage in mental health services.

Contact: Natasha Wright, LCSW