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ACCESS TO MENTAL HEALTHCARE AND HELP-SEEKING BEHAVIORS AMONG AFRICAN AMERICAN WOMEN WITH DEPRESSIVE SYMPTOMS IN A COMMUNITY-BASED PRIMARY HEALTHCARE CENTER

by

ALLYSON S. BELTON
B.S., BIOLOGY, SPELMAN COLLEGE

A Thesis Submitted to the Graduate Faculty
of Georgia State University in Partial Fulfillment
of the
Requirements for the Degree

MASTER OF PUBLIC HEALTH
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30303

APPROVAL PAGE

ACCESS TO MENTAL HEALTHCARE AND HELP-SEEKING BEHAVIORS AMONG AFRICAN AMERICAN WOMEN WITH DEPRESSIVE SYMPTOMS IN A COMMUNITY-BASED PRIMARY HEALTHCARE CENTER

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AUTHOR'S STATEMENT

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von Deutsch, AW., **Belton, AS**., Flowers-Aime, RE., Wright, J., Williams, C., Paulsen, DF., Newman, G., Silvestrov, NA., Klement, BJ., von Deutsch, DA. (2007). Neutrophil Activation in Transitional Gravity. *Gravitational and Space Biology Bulletin , 20* (2).

Belton, AS, Triplett, SD, and Holden, KB. (2012). *Focus Group Viewpoints: African-America Women on Depression*. 13th RCMI International Symposium on Health Disparities. San Juan, Puerto Rico. December 10-13, 2012.

ABSTRACT

Mental illness is a significant contributor to the global burden of disease. As public health practitioners, we must generate more than sufficient knowledge about mental health and illness in order to identify risk factors, increase awareness, improve treatment, eliminate the overall disparity associated with mental illness, and improve access to care to all affected, including those disproportionally affected by mental illness. Over time, there has been an overall lack of sufficient research studies on depression among African American women. As research in this area grows, it is critical to examine the underlying causative factors that are correlated with this disease and this population in order to provide better treatment options and a global understanding. This project will examine and analyze data obtained from the study assessment as it relates to psychosocial factors as reported by the study participants and generate a conclusion based on these findings. Additionally, this project will look to determine the help-seeking behaviors of these women with access to a primary care physician and/or clinic. Overall, findings from this thesis project will provide an understanding of the specific psychosocial variables affecting African American women with depression and depressive symptoms, as well as provide an understanding of the help-seeking behaviors of African American women, and contribute to the improvement of research in mental health in the United States.

INDEX WORDS: depressive symptoms, African American women, mental health, health behavior, primary care

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I

INTRODUCTION

Background/Statement of the Problem

Increasing numbers of primary healthcare patients are seeking mental and behavioral health services, along with addressing their primary healthcare concerns with general practitioners. Of the various mental illnesses afflicting people, depression is one of the most common mental illnesses. Although it is known that depression affects women at greater rates than men, what is not clearly understood are the disparities among women of different racial/ethnic groups. As it relates to African American women, cultural and social factors are likely to influence the prevalence of depression and help-seeking behaviors for mental healthcare. This thesis will examine the help-seeking behaviors of African American women who present depressive symptoms, who also utilize primary healthcare services in a community based clinic. The first research question posed for this study is: Do help-seeking behaviors related to depressive symptoms vary among women who are currently diagnosed with depression and/or depressive symptoms versus those who are not? The hypothesis is that women with a current presentation of depressive symptoms are more likely to seek help or have a history of seeking help for depressive symptoms than women without a diagnosis. Additionally, we would like to ascertain the reliability of the Patient Health Questionnaire (PHQ-9) and the Beck Depression Inventory, Second Edition (BDI-II)

when used to assess depressive symptoms in African American women. The hypothesis is that these two assessments are highly reliable within this specific population.

Purpose of the Study

This project is a secondary data analysis of the *Ladies First!* Study (Principal Investigator: Kisha B. Holden, PhD, MSCR), a randomized control study conducted among African American women with depressive symptoms who received medical care in a community-based primary healthcare center. This project will examine and analyze data obtained from the study assessment as it relates to psychosocial factors as reported by the study participants and generate a conclusion based on these findings. Additionally, this project will look to determine the help-seeking behaviors of these women with access to a primary care physician and/or clinic. Overall, findings from this thesis project will provide the student researcher with an understanding of the specific psychosocial variables affecting African American women with depressive symptoms, as well as provide an understanding of the help-seeking behaviors of African American women, and contribute to the improvement of research in mental health in the United States.

Theoretical Framework

Health Belief Model: The Health Belief Model is a social-psychological model that focuses on the consideration of a person's perception of an illness and that person's reaction to the disorder (Rosenstock, 1974). This model contains five (5) constructs that describe what leads to an individual's decision to pursue a specific health behavior: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action. The underlying concept of this model is that personal beliefs will influence one's health behavior.

Perceived susceptibility refers to an individual's belief of contracting an illness based on his/her current course of action; the greater one sees his/her risk, the more likely he/she will adopt certain behaviors to decrease that risk (Waite and Killian, 2008; DiClemente, Salazar, and Crosby, 2012). Perceived severity refers to the seriousness of the illness as seen by the individual and the associated consequences that come with the illness. Perceived benefits refer to the individual's opinion of how valuable, or beneficial, the new behavior would be to reduce the seriousness of the illness and its consequences. Perceived barriers refer to the disadvantages that are associated with the new behavior or what may hinder the individual from adopting the new behavior (Hayden, 2009). Finally, cues to action are the "events, people, or things" that will shift an individual towards a behavior change (Hayden, 2009).

This model can be used to explain how African American women who are depressed or exhibit depressive symptoms work towards decisions on seeking help through mental health services/practitioners, as well as the acceptance of the prescribed treatment for depression. It takes into account the women's respective health beliefs and the influence of factors such as, family, culture, economics, and value systems on their respective beliefs (Waite and Killian, 2008).

Relevance

Depression can affect anyone of any age, any ethnic or racial group, and within any geographical location. When left untreated, depression is associated with high healthcare utilization, such as excessive use of healthcare resources and high frequency of emergency room visits due to self-inflicted injury (Greenberg et al., 2003). Untreated depression also results in poor quality of life; as well as, negative economical impact as a result of workplace disruption, high rates of absenteeism, and occupational impairment (Wells et al., 2000). It can also have

significant impact of family interactions, creating family disruptions due to divorce and separation and failure to thrive syndromes in children of mothers with depression and other comorbidities (Boyd, Henderson, Ross-Durow, and Aspen, 1997).

Prevalence rates of African Americans seeking mental health services for depression in primary care facilities are increasing, indicating that African Americans are presenting more frequently with depressive symptoms than other groups (Dwight-Johnson, Unutzer, Sherbourne, Tang, et al., 2001). This still does not negate the fact that African Americans have reduced access to both mental health and health service facilities when compared to other groups as reported in the Surgeon General's 2001 report. Even when given access, individuals within this group are less likely to receive the help that they need, such as antidepressant medication (Melfi, Croghan, Hanna, and Robinson, 2000), even though there is a strong willingness to participate in mental health counseling (Blazer, Hybels, Simonsick, and Hanlon, 2000). Misdiagnoses, underdiagnoses, and undertreatment of depression in African Americans, especially African American women, are all too common as a result of lack of knowledge and supporting data which can lead to insufficient treatment of major depressive disorders in this specific population (Carrington, 2006). It is important to focus attention on providing access to care to adequate, culturally-competent mental health services within a primary healthcare setting to promote a positive impact on help-seeking behaviors that can reduce the disparities surrounding African American women and depression and improve overall clinical outcomes.

II

LITERATURE REVIEW

Women and Depression

Major depressive disorder can affect any person at any time of their lifetime. It affects approximately 14.8 million people annually and women ages 18 to 45 accounted for the largest population affected within this group (NIMH, 2012). It is estimated that one in four women is likely to suffer from a depressive episode at some point in her lifetime (NAMI, 2012). Other studies concur that women are nearly twice as likely to experience depression as men, with a lifetime prevalence of major depression in adults to be 17% for women and 9% for women (McKnight-Eily et al., 2009; Hasin et al., 2005).

Annually, as much as seven (7) million women in the United States between 25 and 40 years of age are diagnosed with major depression (Carrington, 2006). They make an estimated 3 million visits to mental health professionals a year and are more inclined to be at greater risk for major depression onset and maintenance when compared to men (Kessler, 2003). Women, when compared to men, have a higher risk of initial and first onset of depressive symptoms that may occur at any point in life (McGrath, Keita, Strickland, and Russo, 2001).

African American Women and Depression

It has been found that depression may have more chronic, severe, and disabling effects on African Americans than other ethnic groups (Williams et al., 2007). Depression rates for African American women are typically inconsistent and cannot be

generalized to a specific population (Hunn and Craig, 2009), as they are commonly misdiagnosed or underdiagnosed for depression or depressive symptoms, therefore making it difficult to ensure proper treatment for this disorder. Inadequate treatment, comorbid medical and psychiatric illness, and various socioecological factors have been cited as overlapping factors contributing to the overwhelming expression of depression and depressive symptoms in African American women when compared to their counterparts in other ethnic groups, as well as compared to men of any ethnic group (Williams et al., 2007). Sufficient recognition and treatment of major depression within this specific population is adversely impacted by somatic clinical presentation, stigma, comorbid medical issues, lack of primary care services and health insurance, and physician-patient relationship problems (Das et al., 2006).

Risk Factors for Depression

African American women are disproportionately at risk for depression because of gender, low socioeconomic status, being never married, and having inadequate to no health insurance coverage (U.S. Department of Health and Human Services, 2001). Current or past stressful life events are significant environmental risk factors in developing depression (Kendler, Karkowski et al., 1999; Chapman, Whitfield et al., 2004). There is a proportional relationship between the risk of depression and the number of stressful life events; the more stressful life events one handles, the more likely she is at risk for developing depression (Hettema et al., 2006). Additionally, African American women tend to confront multiple issues at one time, such as work-life balance, personal relationships, fostering identity development, and creating a purpose in life leading towards success and achievement (Taylor and Holden, 2009). Racism and sexism contribute to the provocation of additional stressors that also increase the likelihood of depression. For example, in a cross-sectional study conducted by McKnight-Eily et al (2009),

correlations were established between depression and poor social support, problematic employment/work issues, difficulties managing physical health problems, and general dissatisfaction with life.

Economic responsibility and challenges contribute greatly to an African American woman's risk of depression. The Department of Health and Human Services reported that in 2010, 32% of African American women represented single-family household, which is greater than other ethnic groups. The responsibility to maintain a household as a primary caregiver and breadwinner can at time become overwhelming and lead to depression as a result of the lack of financial or emotional support.

Mental Healthcare and Primary Care

A large percentage of individuals receive all or part of their mental health treatment in primary care settings (Cooper-Patrick, 1997), but minorities in particular are more likely to report depressive symptoms to primary care physicians than to mental health practitioners (Alegria et al., 2008; Pingitore, Snowden, Sansome, and Klinkman, 2001; Snowden, 2001). The passage of the Mental Health Parity and Addiction Equity Act (MHPAE) of 2008 was a critical step towards ensuring that those with mental illness could receive covered care within the mainstream healthcare system by requiring parity of behavioral health services with other commonly covered medical services (SAMHSA, 2008; Barry and Huskamp, 2011). Combined with the passage of the Patient Protection and Affordable Care Act (PPACA) of 2010, the potential for expanding mental and behavioral health services increases as the opportunity to integrate these services into primary care services and improve the overall quality in the delivery of these services (Mechanic, 2011).

The current delivery of mental and behavioral health services has been deemed "highly fragmented" and flawed, which contributes to overall poor health outcomes and several unmet needs (Druss and Mauer, 2010; Croft and Parish, 2012). At the primary healthcare level, mental disorders typically go undiagnosed or unnoticed due the lack of provider training to recognize the symptomatology of various mental illnesses and therefore patients are without critical care for their respective illness, which eventually increases in severity. Conflicts at the policy, regulatory, and statutory levels not create problem for the patient, but they also create problems for the providers and administrators (Mechanic, 2012). Difficulty in navigating care, billing issues, inconsistent treatment, and duplication of services frequently affect the quality of care received by the patient and given by the provider. Without the integration of services to improve the total well-being of a person, the disease burden created by mental illness will continue to grow in stature and have a detrimental effect on the total population.

Help-seeking Behaviors for Mental Healthcare among Women

When compared to males and women of differing ethnicities, reports indicate that African American women make approximately 3 million mental health visits each year; and also reported to have a higher risk of initial episode and onset of depression as compared to men in (McGrath et.al, 2001; Alegria et.al, 2008). One of the challenges in the treatment of depression and other disorders is the lack of cultural sensitivity. Hunn and Craig (2009) discuss within their article several necessary components to effective treatment of African American women with depression. One suggestion was the initiation of culturally competent practices that acknowledge the socioecological aspects of African American women. Acknowledging the role of family, community, church, religiosity, and spirituality in an African American woman's

psychological well-being is essential to not only properly diagnosing depression, but bringing about effective treatment measures (Hunn and Craig, 2009).

Stigmatization and barriers to care have a great effect on the likelihood of one to seek mental healthcare or not. One study on help-seeking behaviors in African American women found mental health treatment seeking barriers included poor access to care, stigma, and lack of awareness about mental illness (Ward et al, 2009). Additionally, in this population, failure to perceive the need for care, may in part account for the low rates of care for depression among this population (Nadeem et al., 2009).

Reliability and Validity of the Patient Health Questionnaire (PHQ-9) and the Beck Depression Inventory, Second Edition (BDI-II)

Variations in reliability and validity of diagnostic methods and procedures can be and addressed in controlled clinical studies and especially where the populations are ethnically and culturally different from populations on which the assessment instruments were standardized (Carrington, 2006). Several studies have employed the Patient Health Questionnaire (PHQ-9) as a tool of identifying depressive symptomology in several populations. Martin, Rief, Klaiberg, and Braehler (2006) have written that the assessment has good reliability and validity in adult populations. Additionally, Kroenke, Spitzer, and Williams (2001) conducted validity testing in a primary care setting, as well as in an obstetrics/gynecology setting and found a Cronbach's alpha of 0.89 in the primary care study and a Cronbach's alpha of 0.86 in obstetrics/gynecology study. As related to the Beck Depression Inventory, Second Edition (BDI-II), Cronbach alpha internal consistency reliabilities have been reported for several studies, including a 0.91 coefficient among a non-clinical sample of women (Peden, Hall, Rayens, and Bebee, 2000); Whisman, Perez, and Ramel (2000) reported a coefficient alpha of 0.89 among an ethnically diverse sample

of students at a large, urban university and Dozois, Dobson, and Ahnberg (1998) reported a coefficient of 0.89 among a community sample.

III

METHODOLOGY

Research Study Design

The parent study is a randomized control trial examining the effects of a resilience-based intervention on African American women with depressive symptoms who seek care within a community- based primary healthcare setting. Research participants, upon enrollment, were randomly assigned to either the Control Group or to the Intervention Group. Further details on participant selection and study activities are discussed below.

Participant Selection

Adult African American women from the metropolitan Atlanta area that attended the Morehouse Medical Associates Comprehensive Family Healthcare Center (CFHC) were eligible for study participation. CFHC is a community-based primary healthcare center located in East Point, Georgia. Services offered at the CFHC include family medicine, psychological services, nutrition services, social support services, and health education.

Study participants were selected based upon meeting inclusion/exclusion criteria. The inclusion criteria are as follows:

- Females 18 and older who self-identified as African American or Black. A broad age range was selected to allow for comprehensive representation of women at various time periods in life, experiencing an array of life events, and employing a

- variety of coping mechanisms in order to contend with the assorted psychosocial stressors affecting their respective lives.
- Current patient of the Morehouse CFHC with a scheduled personal appointment at the time of recruitment.

Exclusion criteria are as follows:

- Any subject who is unable to give informed consent.
- Any subject who is not scheduled for a personal appointment at the time of recruitment or is in the clinic as a visitor with another patient.

Research Procedures

Assessments

In the parent project, several paper-and-pencil psychosocial measures were administered to the research participants. All of these assessment measures have adequate psychometric properties as suggested by reliability and validity information reported in the literature; and based on the previous use of these tools in other investigations that involved African Americans that have been conducted by the principal investigator of the parent project, Dr. Kisha Holden. The following three (3) assessments will be used to address the research questions of the thesis.

Demographic/Background Questionnaire. A demographic questionnaire was developed a by the investigator to query background information about the respondent. Background information gathered included: age, ethnicity, marital status, education, household income, health insurance status, number of children, employment status, and profession. A series of questions about one's personal history and treatment for depression was also included. Finally, two open-ended questions were included, asking the following: (1) What issues and/or concerns do you think may contribute to African American women that experience depression?

and (2) What strategies do you think would help African American women to cope better with depression?

Depression Screening Tool. The Patient Health Questionnaire (PHQ-9) is a nine (9)-question, self-administered tool of proven validity and reliability, which is commonly used in primary care practices to screen patients for depression (DeJesus, Vickers, Melin, and Williams, 2007). The questions within the tool are based on the *Diagnostic and Statistical Manual of Mental Disorders* (4th Edition) diagnostic criteria. Questions posed within the questionnaire address personal feelings of depression, personal interest in life, and changes in personal habits or ideas over the last two (2) weeks. In applying the scores to practice, one is considered to present mild symptoms of depression upon scoring within the range of 5-9. Major depression can be provisionally diagnosed with scores ranging from 10 to greater than or equal to 20; severe depression is provisionally diagnosed with scores greater than or equal to 20.

Measure of Depressive Symptoms. The Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer, and Brown, 1996) was used to assess the outcome variable depressive symptomatology. The BDI-II is a 21-item self-report inventory designed to assess affective, behavioral, cognitive, motivational, and vegetative aspects of depressive symptomatology. Each item requires the respondents to select one of four graded statements, reflecting the severity of different depressive symptoms pertaining to past two weeks. For example, the item on sadness allows participants to support any one of four (4) sentences ranging from "I do not feel sad," "I feel sad much of the time," "I am sad all of the time," and "I am so sad and unhappy that I can't stand it." Scores from zero (normal) to three (3) (severe) are applied to each sentence within the items. Individual item scores are summed together for a total score that can range from 0 to 63. Higher scores denote greater severity of overall depression. According to cut-off scores and

interpretative labels of depressive symptoms among non-clinical samples, a score of 9-17 is considered "mild," 18-28 is regarded as "moderate," and a score of 29 and above is indicative of "severe" depressive symptoms.

Recruitment and Enrollment

Interested subjects who, based on the inclusion/exclusion criteria, were eligible for participation were approached by a research assistant and provided information on the study. Upon providing consent to participate, the subject was asked to complete the PHQ-9, which was scored by the research assistant following completion. All subjects scoring greater than or equal to 10 were invited to complete the pre-intervention assessment tool, which contained the previously mentioned battery of assessments, and enrolled in the study. Upon completion of the pre-intervention assessment, subjects were randomized to either the Intervention Group or the Control Group. The Intervention Group engaged in four (4) educational sessions with a curriculum focused on depression education and resilience. The Control Group met on one (1) occasion five (5) weeks after taking the initial assessment to take one (1) additional assessment.

Data Analysis

Quantitative data analyses were carried out through the use of the Statistical Package for the Social Sciences (SPSS 17.0, 2008). Basic descriptive statistics such as mean, standard deviation, standard error of the mean, range, proportion and 95% confidence intervals describe continuous and/or nominal or categorical variables. Pearson product moment correlation analyses were utilized to determine significant relationships between depressive symptomatology (PHQ-9 and the BDI-II) and the psychosocial variables of interest. Chi-square analyses and Fisher's Exact Test were used to determine the significance between personal history of

depression and help-seeking behaviors. Finally, Cronbach's alpha reliability coefficients were generated for each of the assessment tools in order to determine their psychometric applicability to the target population under investigation.

IV

RESULTS

Study Population and Demographics

The total study sample included 187 women from various socioeconomic backgrounds. The majority of the women (n=170, 96.1%) identified as African American; the remainder of the women identifying as African (n=1, 0.6%), Caribbean (n=4, 2.2%), and other (n=2, 1.1%). Ten women within the sample did not report their ethnicity. The mean age was 41 years (SD=14.14).

There were a total of 61 participants within the study that were classified as depressed according to their respective PHQ-9 score. As reflected in the total study sample, the majority of the women identified as African American (n=56, 91.8%). Two (2) women each (3.3% each) identified as Caribbean or other. Finally, one (1) woman (1.6%) identified as African.

Marital Status and Children

Approximately 44% of the total participants reported they were single (n= 74) and 28% reported they were married (n = 47), 16.1% reported they were divorced (n = 27), 5.4% reported they were widowed (n=9), and 6.5% indicated that they were cohabitating with a partner (n=11). Many of the women (n = 90, 52.3%) reported having one (1) to two (2) children, some women (n= 38; 22.1%) indicated having at least three (3) children, and 25 women (14.5%) reported having four (4) or more children. Nineteen of the women (11%) reported that they did not have any children.

As for the depressed participants, 44.4% of the women reported they were single (n=24). Twelve women (22.2%) reported that they were divorced, whereas 18.5% reported that they were married. There were four (4) participants (7.4%) who indicated that they were widowed, as with the women who were cohabitating with a partner. A number of women (n=18, 31.6%) had three (children), whereas 13 women (22.8%) had two (2) children. Approximately 21% of the women had four (4) or more children, eight (8) women (14%) had only one (1) child, and six (6) women (10.5%) stated that they had no children.

Employment and Education

Forty-three percent of the study participants (n=78) reported being employed full-time, followed by 19.9% who reported that they were unemployed (n= 36). In regards to education, approximately 27.8% of respondents (n=49) reported completing some college, and others indicated completion of a high school diploma (n=36, 20.5%). Other women (n=29; 16.5%) reported technical or vocational school training; college graduates made up 15.3% of the study population (n=27); and 7.4% of the women reported completion of a post graduate/professional degree (n=13). Only a few women (n=17; 9.7%) had only completed some high school; even fewer women (n=4, 2.3%) reported completing only middle or grade school and even one (1) woman reported no schooling.

Household Income

Within the total sample, approximately 70.1% of the women (n=122) were classified as somewhat low income (<$5,000 to $34,999), 25.3% of the women (n=44) were classified as middle income ($35,000 to $74,999), and few women (n =8; 4.5%) were classified as high income ($75,000 to >$250,000). Within the depressed sample, 82% of the women (n=55) were

classified as somewhat low income and the remainder of the women (n=11, 18.1%) were classified as middle income.

History of Diagnosed Illness

Several of the women within the total sample reported various health problems. There was a mean of 4.08 (SD=1.69) diagnosed illnesses within the total study sample. In particular, 46.5% (n=87) of the women reported being previously diagnosed with hypertension. Following hypertension were reports of depression (n=55, 29.4%), anxiety (n=36, 19.3%), chronic pain (n=34, 18.2%), arthritis (n=32, 17.1%), diabetes (n=31, 16.6%), asthma (n=30, 16%), sexually transmitted disease (n=23, 12.3%), and cancer (n=13, 7%). Only a few women reported health problems such as reproductive problems/infertility (n=6, 3.2%), stroke (n=6, 3.2%), substance abuse (n=5, 2.7%), heart attack (n=4, 2.1%), lupus (n=3, 1.6%), and HIV/AIDS (n=1, 0.5%). Twenty-four women (12.8%) reported other diagnosed health conditions that they had experienced.

Health Insurance Coverage

Nearly half of the participants (n=91, 50.2%) indicated that they utilized government-subsidized health insurance coverage (Medicaid and Medicare) as their primary source of insurance coverage. Others used either an HMO or PPO (n=60, 33.2%) or private insurance (n=10, 5.5%). There were 16 women (8.8%) who indicated that they had no insurance coverage. Within the depressed population, the majority of the women also utilized government-subsidized insurance (n=44, 69.8%). Thirteen women (20.6%) had an HMO, a PPO, or private insurance coverage. Only five (5) women (7.9%) did not have any insurance coverage. These results, as well as the aforementioned demographic information can be found in Table 1.

Table 1

Study Demographic Information

	Total		Depressed Women	
	N	%	N	%
Ethnicity				
African American	170	96.1	56	91.8
African	1	.6	1	1.6
Caribbean	4	2.2	2	3.3
Other	2	1.1	2	3.3
Marital Status				
Single	74	44.0	24	44.4
	N	%	N	%
Married	47	28.0	10	18.5
Divorced	27	16.1	12	22.2
Widowed	9	5.4	4	7.4
Cohabitating/Living Together	11	6.5	4	7.4
Number of Children				
None	19	11.0	6	10.5
One	46	26.7	8	14.0
Two	44	25.6	13	22.8
Three	38	22.1	18	31.6
Four or more	25	14.5	12	21.1
Employment Status				
Unemployed	36	19.9	16	25.0
Part-time	14	7.7	4	6.3
Full-time	78	43.1	20	31.3
Temporary	4	2.2	1	1.6
Retired	15	8.3	5	7.8
Disabled	24	13.3	15	23.4
Student	8	4.4	1	1.6
Homemaker	2	1.1	2	3.1
Highest Level of Education				
No School	1	.6	0	0
Middle or Grade School	4	2.3	3	4.9
Some High School	17	9.7	10	16.4
High School Graduate	36	20.5	12	19.7
Technical or Vocational School	29	16.5	8	13.1
Some College	49	27.8	16	26.2
College Graduate	27	15.3	11	18.0
Post Grad/Professional Degree	13	7.4	1	1.6
Total Household Income				
Under $5000	40	23.0	20	32.8
$5,000-$9,999	16	9.2	10	16.4

	Total		Depressed Women	
$10,000-$14,999	21	12.1	10	16.4
$15,000-$24,999	18	10.3	5	8.2
$25,000-$34,999	27	15.5	5	8.2
$35,000-$49,999	25	14.4	4	6.6
$50,000-$74,999	19	10.9	7	11.5
$75,000-$99,999	3	1.7	-	-
$100,000-$149,999	1	.6	-	-
$150,000-$199,999	2	1.1	-	-
$200,000-$249,999	0	0	-	-
$250,000 and over	2	1.1	-	-

Reliability of the PHQ-9 and BDI-II

Cronbach's alpha reliability analyses were conducted for each assessment measure to determine their respective reliability when applied to this particular study population. Both the Beck Depression Inventory, Second Edition (BDI-II) and the Personal Health Questionnaire-9 (PHQ-9) were found to be extremely reliable in the total sample (α=0.911 and α=0.914, respectively). The BDI-II was found to be extremely reliable in the depressed population (α=0.828); however, the PHQ-9 was found to be not as reliable within this same group (α=0.691). These findings imply that these measures are appropriate instruments to use with African American women; however, further reliability testing will need to be completed on the PHQ-9 to use with depressed African American women.

Depression Symptoms among Study's Sample

On the Beck Depression Inventory, Second Edition (BDI-II), interpretive scores of depression severity indicate that a score of eight (8) or less is considered minimal, nine (9) to 17 is considered mild, 18-28 is considered moderate, and a score of 29 and above is indicative of severe depression. On the Personal Health Questionnaire-9 (PHQ-9), interpretive scores of depressive symptomology indicate that a total score of one (1) to four (4) is considered minimal,

five (5) to nine (9) is considered mild, 10 to 14 is moderate, 15 to 19 is considered moderately severe, while 20 and above is indicative of severe depressive symptomology.

Total Population

The mean BDI-II score within the total study sample was 14.50 (*SD*=12.14). Among the total sample, 53.8% of the women scored in the minimal range, 18.2% of the women scored in the mild range, 12.6% scored in the moderate range, and 15.4% scored in the severe range. These findings can be found in Figure 1. The mean PHQ-9 score within the total study sample was 7.91 (*SD*=7.03). Among the total sample, 46.2% reported no depressive symptomology, 17.9% women reported minimal symptomology, 15.2% reported mild symptomology, 9.8% reported moderately severe symptomology, and 10.9% of the women reported severe depressive symptomology. These findings can be found in Figure 2.

There was a strong bivariate correlation found (*r*=.825) between the PHQ-9 and the Beck Depression Inventory within the total sample of participants.

Figure 1: BDI Ranges by Designation (Total Sample). This figure illustrates the proportions of BDI ranges within the total sample population.

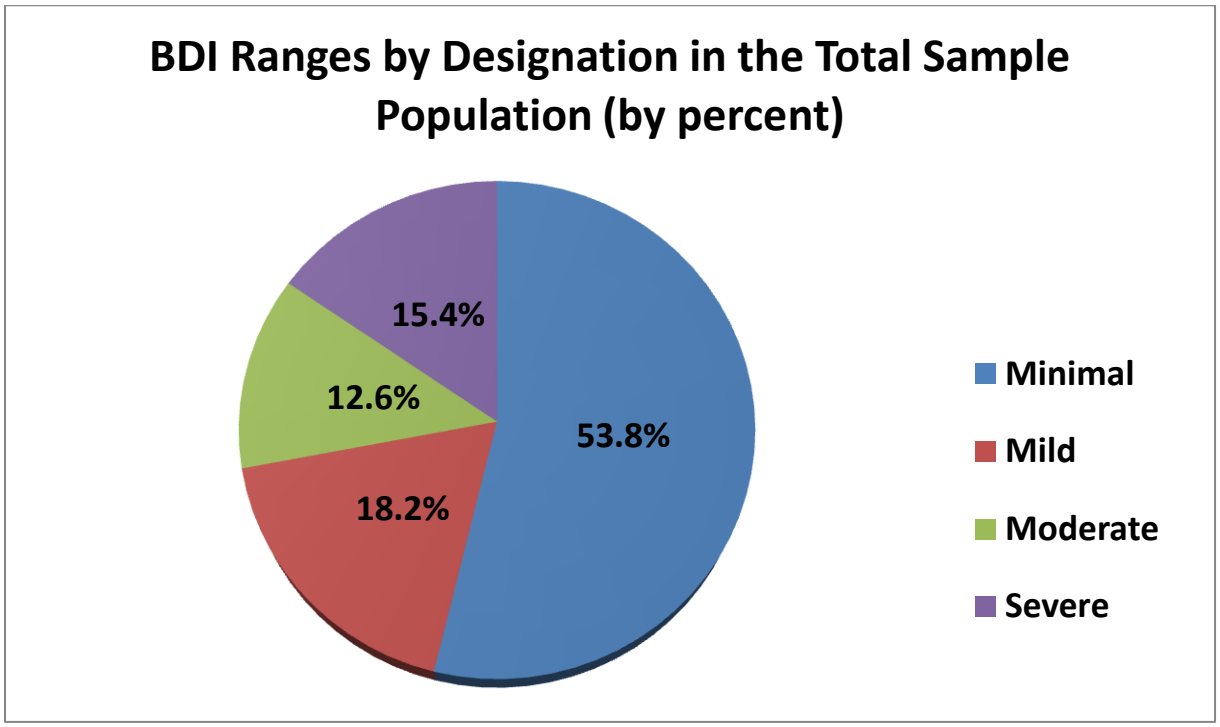
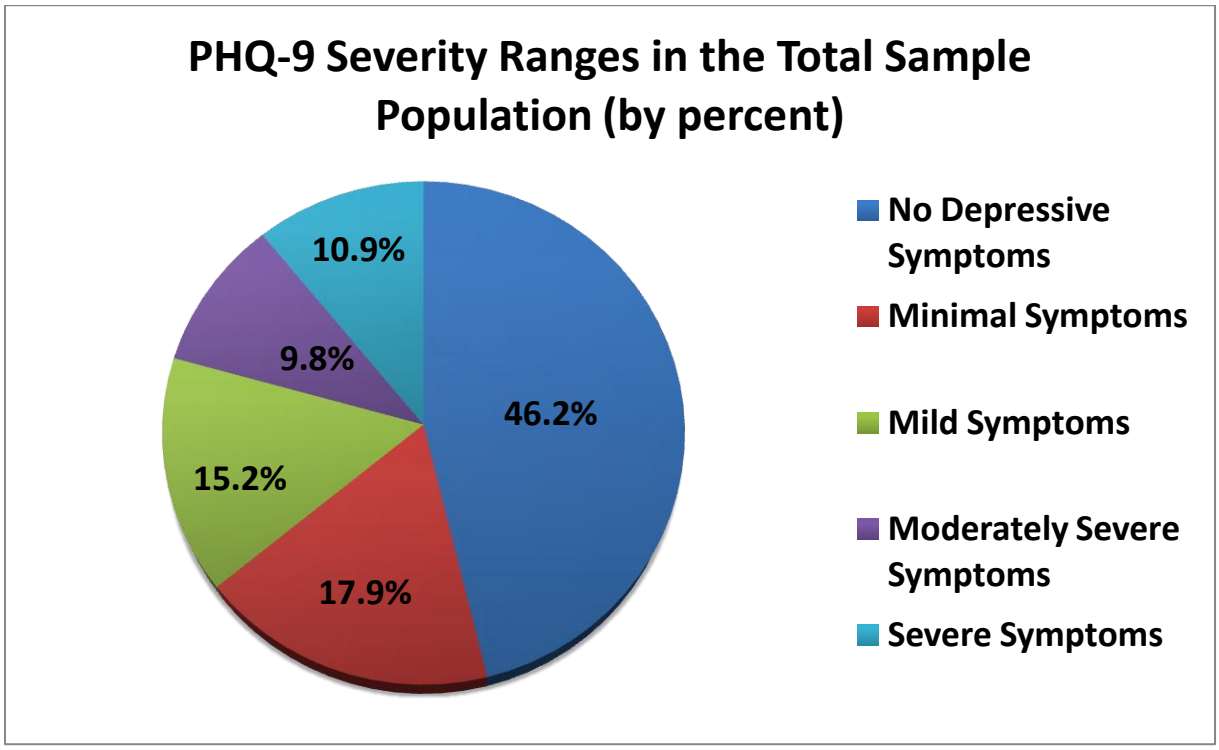


Figure 2: PHQ-9 Severity Ranges (Total Sample). This figure illustrates the proportions of PHQ-9 ranges within the total sample population.



Depressed Population

The mean BDI-II score within the depressed sample was 26.02 (*SD*=11.08). Among the depressed sample, 7.8% of the women scored in the minimal range, 25.5% of the women scored in the mild range, as well as in the moderate range, and 41.2% scored in the severe range. These findings can be found in Chart 3. The mean PHQ-9 score within the depressed sample was 16.06 (*SD*=4.67). Among the depressed sample, only one (1) woman reported no depressive symptomology and no one reported minimal symptomology. Forty percent reported mild symptomology, 27.7% reported moderately severe symptomology, and 30.8% of the women reported severe depressive symptomology. These findings can be found in Chart 4.

There was a strong bivariate correlation found (*r*=.655) between the PHQ-9 and the Beck Depression Inventory within the depressed sample of participants.

Figure 3: BDI Ranges by Designation (Depressed Women). This figure illustrates the proportions of BDI ranges within the depressed population.

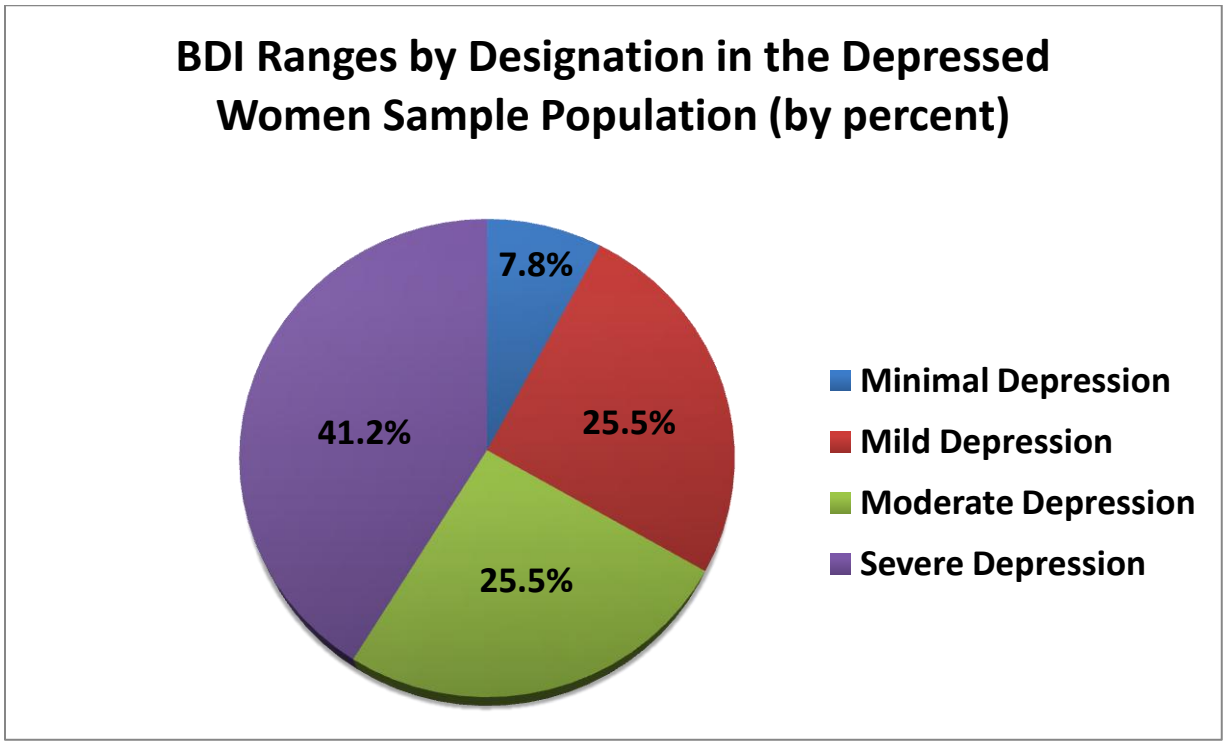
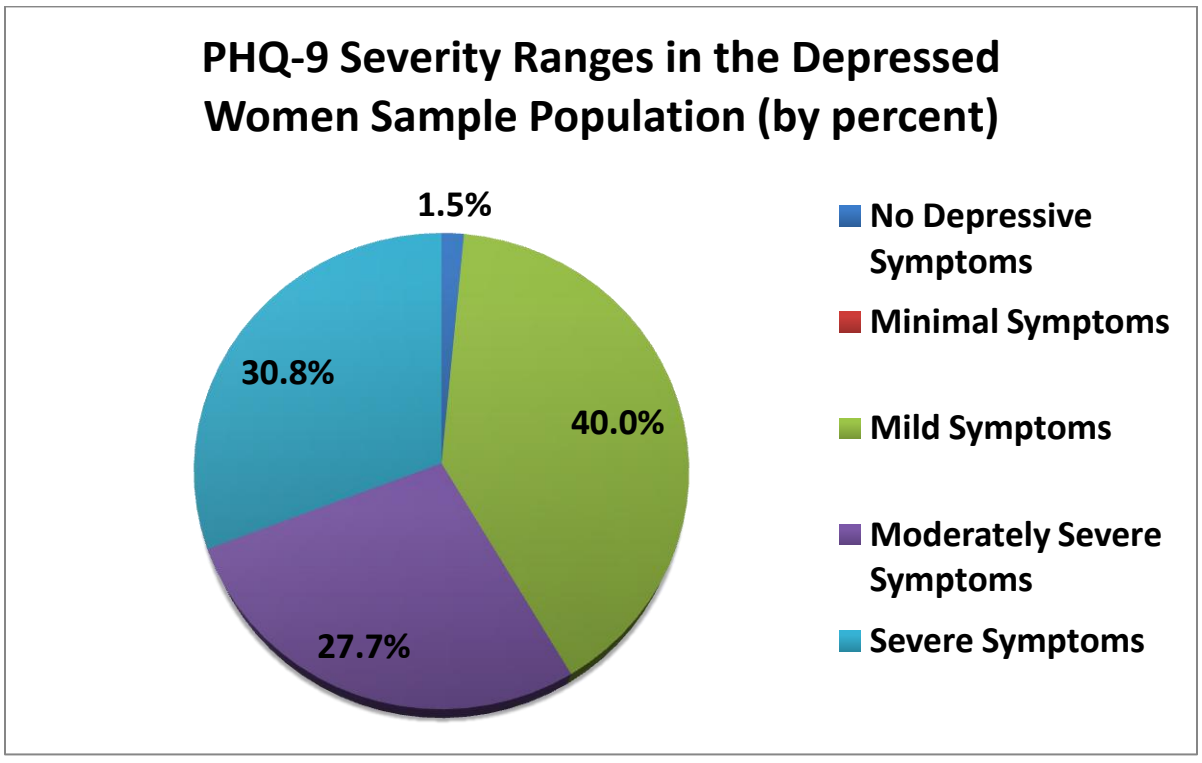


Figure 4: PHQ-9 Severity Ranges (Depressed Women). This figure illustrates the proportions of PHQ-9 ranges within the total sample population.



Frequency of BDI Responses

There was also effort to review the specific depressive symptoms that were endorsed by the total sample population, as well as the depressed sample, by examining the frequency of reported symptoms based on the BDI-II. Findings indicated the following outlook of the total sample of study participants from some of the constructs.

- Sadness: 36.4% of the women (n=64) reported feeling sad much of the time.
- Pessimism: 28% of the women (n=45) reported feeling more discouraged about their future than they used to be.
- Past Failure: 31.8% of the women (n=56) reported that they felt they have failed more than they should have.
- Self-Dislike: 18.6% of the women (n=33) reported that they are disappointed in themselves.
- Self-Criticalness: 24.2% of the women (n=43) reported that they are more critical of themselves than they used to be.
- Crying: 23% of the women (n=41) reported that they cry more than they used to.
- Loss of Interest: 32% of the women (n=57) reported that they are less interested in other people or activities.
- Irritability: 34.8% of the women (n=62) reported that they are more irritable than usual.

As for the depressed sample, the following was found for the same constructs:

- Sadness: 62.9% of the depressed women (n=39) reported feeling sad much of the time.
- Pessimism: 42.4% of the depressed women (n=25) reported feeling more discouraged about their future than they used to be.

- Past Failure: 46% of the depressed women (n=29) reported that they felt they have failed more than they should have.
- Self-Dislike: 41.3% of the depressed women (n=26) reported that they are disappointed in themselves.
- Self-Criticalness: 36.5% of the depressed women (n=23) reported that they are more critical of themselves than they used to be.
- Crying: 23% of the women (n=41) reported that they cry more than they used to.
- Loss of Interest: 52.4% of the depressed women (n=33) reported that they are less interested in other people or activities.
- Irritability: 43.1% of the depressed women (n=28) reported that they are more irritable than usual.

Personal History of Depression

It was also important to review the personal history of depression as it relates to the total sample population, as well as the depressed sample. Findings indicated the following perspective of study participants from some of the questions on the Personal History of Depression questionnaire. Of the total study sample, 54.3% of the women (n=95) indicated that they have suffered from depression at some time. Likewise, 33.9% of the women (n=62) stated that they have taken a medication for depression, 20.9% of the women (n=38) have participated in individual psychotherapy sessions for depression, 76.0% of the women (n=139) are comfortable talking with their primary care physician about their personal problems, and 75% of the women (n=132) are comfortable with talking with a mental health specialist about their personal problems. Additional questions and reported responses are found in Table 2.

A chi-square test was performed and there was a significant relationship found between personal history of depression and the likelihood of seeking help for depression in two (2) different methods among the women who did not qualify for the study (PHQ-9 score of less than 10).

- Anti-Depressant Usage: $X^2(1, N = 183) = 34.43, p<.001$.
- Individual Psychotherapy: $X^2(1, N = 182) = 16.51, p<.001$.

Table 2

Personal History of Depression (All)

	Total Population (All Respondents)		Non-Depressed Women		Depressed Women		p-value
	N (yes)	% of Total Population	N(yes)	% of Non-Depressed Women	N(yes)	% of Depressed Women	
Have you ever suffered from depression?	95	54.3	43	38.7	52	81.3	<.001
Have you ever taken any type of medication for depression?	62	33.9	22	18.6	40	61.5	<.001
Have you ever participated in individual psychotherapy sessions for depression?	38	20.9	14	11.9	24	37.5	<.001
Have you ever participated in a support group to help with your depression?	21	11.5	10	8.5	11	16.9	.095
Have you received spiritual guidance or religious support to help with your depression?	66	36.3	36	30.8	30	46.2	.053
Do you feel comfortable talking with your primary care doctor about your personal problems?	139	76.0	87	73.7	52	80.0	.210
Do you feel comfortable talking with a mental health specialist, such as a psychiatrist or psychologist about your personal problems?	132	75.0	81	71.1	51	82.3	.074
Does anyone in your family suffer with depression?	65	37.1	32	28.1	33	54.1	.001

Special attention was given to personal history of depression in the depressed women sample with regard to BDI range. In examining the same questions as presented above, the following findings were noted:

- Have you ever taken any type of medication for depression? Based on 51 respondents, 15 women who scored in the severe range indicated that they have taken medication for their depression. Additionally, eight (8) women each in the mild and moderate ranges, respectfully, have indicated medication usage; however, there were no women reported to have taken any medication for depression.
- Have you ever participated in individual psychotherapy sessions for depression? Based on 50 respondents, 12 women in the severe range indicated that they have participated in such sessions. Likewise, three (3) women each in the mild and moderate ranges, respectfully, have indicated participation in individual psychotherapy session. As in the case with medication usage, there were no women who scored in the minimal group to report that they sought psychotherapy in an individual session.
- Do you feel comfortable talking with your primary care doctor about your personal problems? Based on 48 respondents, the general consensus was that women who scored any BDI range would be comfortable in talking with their primary care doctor about personal problems. In the minimal range, there were three (3) women who responded yes, 11 in the mild range, 12 in the moderate range, and 17 in the severe range.
- Do you feel comfortable talking with a mental health specialist, such as a psychiatrist or psychologist about your personal problems? Based on 48 respondents, the results were very similar in nature to the previous question. Three (3) women in the minimal range stated that they would be comfortable speaking with a mental health specialist, 11 women in the mild range stated that they would be comfortable speaking with a mental health specialist and 17 women in the severe range stated that they would be comfortable. Unlike the previous question asking if one would be comfortable speaking to their

primary care doctor, only nine (9) women in the moderate range stated that they would be comfortable speaking to a mental health specialist.

Additional information is found in Table 3. A Fisher's Exact Test was run because more than 25% cells have expected value less than five (5), finding that there was no significant relationship found between personal history of depression and the likelihood of seeking help for depression in various methods.

Table 3

Personal History of Depression by BDI Range (Depressed Women)

		BDI Ranges				
		Minimal	Mild	Moderate	Severe	p-value
Have you ever taken any type of medication for depression?						
	Yes	0	8	8	15	0.0716
	No	4	5	5	6	
Have you ever participated in individual psychotherapy sessions for depression?						
	Yes	0	3	3	12	0.0617
	No	4	10	9	9	
Have you ever participated in a support group to help with your depression?						
	Yes	0	2	1	6	0.4395
	No	4	11	12	15	
Have you received spiritual guidance or religious support to help with your depression?						
	Yes	0	6	6	10	0.4099
	No	4	7	7	11	
Do you feel comfortable talking with your primary care doctor about your personal problems?						
	Yes	3	11	12	17	0.8322
	No	1	2	1	3	

Do you feel comfortable talking with a mental health specialist, such as a psychiatrist or psychologist about your personal problems?						
	Yes	3	11	9	17	0.4635
	No	0	1	4	3	
Does anyone in your family suffer with depression?						
	Yes	3	6	5	12	0.5688
	No	1	7	8	9	

V

DISCUSSION

The purpose of this project was to understand of the specific psychosocial and socioecological variables affecting African American women with depressive symptoms, as well as their help-seeking behaviors in order to answer the research question that investigates if these help-seeking behaviors vary among women with diagnosed depression versus those without. The findings from this study highlight the various contributors that may help to explain issues related to experiences of depressive symptoms and perceptions concerning help-seeking behaviors in this population. The women who participated in this project were diverse on many levels. Demographically, they were diverse in regards to household income, education levels, age, marital status, health insurance coverage, employment status, and history of diagnosed health issues. They each provided a perspective that presented similarities and differences within the study population to contribute to the findings in this paper.

The assessments measures used to assess depressive symptoms, BDI-II and PHQ-9 were found to be reliable for use in this particular population. As such, depressive symptoms, according to the BDI-II, within the total population sample were in the minimal range, strongly correlating with the findings of the results of the PHQ-9, which showed that the majority of the women reported no depressive symptomology. In looking closely at the women's responses on certain concepts associated with depression, the women overall reported little to no change in feelings or belief as related to sadness,

pessimism, past failures, loss of pleasure, guilty feelings and feeling of punishment, self-dislike and self-criticalness, suicidal thoughts/wishes, crying, agitation, and several other concepts associated with depression. There were exceptions to this in regards to loss of energy, changes in sleeping patterns, changes in appetite, and overall tiredness and fatigue. Although this may be associated with depression, these constructs could be more associative to lifestyle habits.

In the depressed population, it was expected to find more women who suffered from mild to severe depression and display some symptomology of depression. It was also expected to see changes in overall feelings and beliefs. These women more frequently reported changes in sadness, pessimism, past failures, loss of pleasure and interest, guilty feelings, self-dislike and self-criticalness, crying, agitation, and other associative constructs. The only exceptions for this population were feelings of worthlessness and suicidal thoughts/wishes, which were more closely aligned with the total population's reporting of these constructs. This can be attributed to the high ideals that African American women hold in regards to their person and placing higher value on life and driven to a sense of survival as opposed to defeat.

When examining personal history of depression, over half of the women in the total population reported that they had suffered from depression at some point in time; however, the women indicated in an overwhelming majority that they were comfortable speaking with their primary care physician or a mental health specialists about their personal problems, which is slightly different from most literature that states that African American women are more prone to seek help from social support systems, such as family, friends, and religion. This finding actually contrasts with the relatively low numbers of women in the total population who have actually participated in individual or group psychotherapy sessions to help with their depression.

There were more women who leaned towards religious support to cope with depression in comparison to the combined numbers of women were who sought individual or group psychotherapy. Wang, et al. (2000) found that even when positive beliefs about treatment are expressed, barriers to treatment may affect with actual treatment utilization. Several women reported various barriers to seeking treatment, such as negative experiences with an individual mental health clinician, insufficient time to seek treatment due to personal life responsibilities, and costs of treatment.

Also, surprising was the number of women who had even taken medication for depression, as the literature and common thought lean towards medications as a highly stigmatized form of care. Studies have shown that African Americans have reported finding medication treatment less acceptable and express greater preference for counseling (Cooper, Gonzales, Gallo, et al., 2003; Newport, Calamaras, Devane, et al., 2007).

In their study, Alvidrez and Azocar (1999) found that women were broadly interested in receiving mental health treatment, expressing more interest in individual therapy and education about health and stress and less interest in medication or group therapy, which is similar to the overall findings of the study. Other studies have found that African American women expressed strong preferences for receiving help from religious and spiritual support and reported personal beliefs in traditional services not being sufficient enough to assist with their individual needs (Amankwaa, 2003).

Additionally, as it relates to the findings of preference of spiritual and religious support, one study has found that women view depression as a psychosomatic that is controllable through positivity and through strengthening their spiritual relationship with God (Waite and Killian, 2008). Another study shows that prayer is a common coping mechanism for African American

women during signs of distress (Browman, 1997). Overall, findings support that women with higher levels of spirituality and greater religious involvement had a positive impact overall on dealing with depression and depressive symptoms (Carrington, 2006; Watlington and Murphy, 2006).

When broken down by levels of severity, those in the depressed group who scored more within the severe range had the higher reporting of taking medication and seeking care at least in individual therapy or through spiritual guidance/religious support. One thing that was consistent among this group is that there was not a great deal of women who opted for group support to help with their depression. Again, this can be attributed to the stigma of keeping issues closeted in order to maintain a level of control and to maintain a positive appearance. Trying to maintain this control and a sense of independence has been defined as *John Henryism*, which is a coping mechanism for overcoming challenges through hard work and determination (Amankwaa, 2003). Those who had mild to moderate depression did seek care and help in various ways, but not as frequently as those in the severe category. This may be attributed to the perception of a less chronic illness and categorizing depression as more intermittent feelings of sadness. This commonly leads to misdiagnoses and underdiagnoses of depression and depressive symptoms because of the general misunderstanding of the context of one's behavior and mannerisms (Vontress, Woodland, and Epp, 2007; Hunn and Craig, 2009).

Women who were depressed had higher rates of family history of depression, anti-depressant usages, and overall care whether through individual psychotherapy, group psychotherapy, or religious support. As reflected in the total population, the depressed women were also willing to speak with their primary care physician or a mental health specialist about their personal problems; and although they were more inclined to seek care, the numbers of

depressed women who participated in individual psychotherapy or group psychotherapy were relatively lower when associated with willingness to seek care. These findings related to help-seeking behavior can be attributed to the overall premise outlined in the Health Belief Model, which states that a person's belief, or acceptance of illness, will determine the course of action that she would take to seek care (Hayden, 2009).

The Health Belief Model can be used to describe the way that the women of this study reached critical decisions about the need to consult a clinician and then follow through to seek and accept care for their depression and depressive symptoms (Waite and Killian, 2008). In most cases, the women within this study minimized their symptomology or did not weigh it as strongly due to trying to maintain a sense of control over their illness or overall denial of the severity of depression. This has been further discussed in Beauboeuf-Lafontant's (2005) analysis of African American feminism, which states that strength allows a woman to reduce emphasis on her struggle and to disconnect from any assistance. The primary conceptualization of womanhood in black women obliges them to show strength by concealing signs of strain and minimizing concern for self (Beauboeuf-Lafontant, 2005). In contrast, Browman (1997) found that a preferred coping strategy for African American women in distress was to confront their problems, as opposed to avoiding them, and seek help from their social support system.

Overall, the women who participated in this study appeared to indicate interest in seeking treatment for depression or depressive symptoms; however, the move to action in actually pursuing care was low when compared to their receptivity of care. In regards to the research question, women with diagnosed depression or depressive symptoms did have a higher likelihood of seeking care for their respective symptomology, regardless of overall interest within the total population. African American women and women in general, face many

challenges that affect their overall health and well-being. Maintaining optimal mental and emotional health, along with physical health, is crucial to facing these challenges and reducing the detriment that can come from them. Providing sufficient access to competent care, especially within a primary care setting, will aid in the care of these women and open doors for more innovative methods to treating depression in this specific population.

Limitations

It is necessary to acknowledge the limitations to this study. First, this project only examines a smaller subset of women located in the metropolitan Atlanta area compared to the overall group of interest. Therefore, further research will be needed to broaden the scope of this area and to find more information that can be generalized across the whole population. Secondly, all data reported were obtained from self-report assessments, which lead to the possibility of inaccuracies in reporting due to recall bias. Women completing the assessments may have had comprehension issues as related to the questions, they may have provided responses in regard to social conventions, or they may have provided responses in haste to complete the assessment.

Implications

Several implications can be made as it relates to this study. One implication is addressing the need for consistent, quality mental health treatment options for this specific population. Clinicians tend to assume that there is a universal psychotherapeutic treatment system that can be applied to all ethnic and racial groups (Baker and Bell, 1999). Currently, there are very few studies that examine African American women and depression, as well as culturally-appropriate methods of care to treat depression and depressive symptoms in this population (Levin et al., 2008; Holden, 2012). Findings from this study can be added to the existing knowledge of this

particular field and increase overall knowledge to make findings more generalizable to this specific population and to devise treatment options based on the needs of those reporting. As such, it is recommended that primary care clinicians devote more time into deriving mental health diagnoses and more time in discussion with patients in regards to their respective mental health, which will lead to better interventions and care strategies for those with depressive symptoms; this will contribute to efforts in preventing the increase of severity of these symptoms.

Additionally, mental illness has grown as an area of interest in public health concerns, especially among African Americans. Several health disparities already plague the African American community when compared to other ethnicities; mental illness and the lack of care only add to these disparities as it too affects access to and utilization of care and increased disability, which can affect one's overall socioeconomic status. The United States (U.S) Department of Health and Human Services, Office of Minority Health reports that African Americans, when compared to non-Hispanic Whites, are approximately 30% more likely to report having some form of mental illness (US DHHS, 2001). African Americans are also less likely to receive proper diagnosis and treatment for mental illnesses and are more likely to experience poorer functioning and greater disability from untreated mental illnesses (Algeria et al., 2008). The American Psychological Association states that "this disparity does not stem from a greater prevalence rate or severity of illness in African Americans, but from a lack of culturally competent care, and receiving less or poor quality care" (APA, 2012).

Findings from this study can not only contribute to the overall research of this area, but most importantly, it could help move research forward towards finding and implementing solutions to this public health issue of mental illness among not just African Americans, but

specifically African American women. Further research could also branch to other members of this ethnic group, such as African American men and African American children to broaden the scope of how depression and depressive symptoms affects this population as a whole. By addressing the concerns approached in the study, public health can continue to approach this problem and move towards a solution to eliminate the disparity.

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APPENDICES

Appendix A: Patient Health Questionnaire (PHQ-9)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1 Patient completes PHQ-9 Quick Depression Assessment.

2 If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1 Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.

2 Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3

3 Add together column scores to get a TOTAL score.

4 Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.

5 Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9
For every ✓ Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3
Interpretation of Total Score

	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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Appendix B: Ladies First! Research Study Assessment Instrument

Culturally Centered Psychosocial Resiliency Empowerment Intervention for African American Women in a Community Based Primary Healthcare Setting

Research Study Assessment Instrument

Phase I Recruitment

2012

Unique ID#: _____

Date: _____

Culturally Centered Psychosocial Resiliency Empowerment Intervention for African American Women in a Community Based Primary Healthcare Setting

Thank you for agreeing to participate in this important research study. Your participation will help us to learn more about the experiences of African American women and mental health. Please complete all of the following questionnaires in their entirety. There are no right or wrong answers, just be truthful about your personal beliefs. Your responses will be kept confidential. If you have any questions, please ask the principal investigator, Dr. Kisha B. Holden at kholden@msm.edu and/or 404-756-8915.

Background Information

Age: _____ **Gender**: _____

Ethnicity	**Marital Status**	**Number of Children**
___African American	___Single	___None
___African	___Married	___One
___Caribbean	___Divorced	___Two
___Other_____	___Widowed	___Three
	___Co-habitating/living together	___Four or more

Employment Status	**Highest Level of Education**	**Total Household Income**	
___Unemployed	___No School	___Under $5000	___$100,000-$149,999
___Part-time	___Middle or Grade School	___$5,000-$9,999	___$150,000-$199,999
___Full-time	___Some High School	___$10,000-$14,999	___$200,000-$249,999
___Temporary	___High School Graduate	___$15,000-$24,999	___$250,000 and over
___Retired	___Technical or Vocational School	___$25,000-$34,999	
___Disabled	___Some College	___$35,000-$49,999	
___Student	___College Graduate	___$50,000-$74,999	
___Homemaker	___Post Graduate/Professional Degree	___$75,000-$99,000	

Health Insurance Coverage

___Uninsured

___Fee for Service/Private Insurance

___Health Maintenance Organization (HMO)

___Preferred Provider Organization (PPO)

___Medicaid

___Medicare

___Other

Profession/Field of Work

___Business/Finance ___Government

___Education ___Computer Technology

___Healthcare ___Construction

___Administrative ___Retail

___Entertainment/Arts ___Food Service

___Communications ___Project Management

___Childcare ___Other_____

Diagnosed Health Conditions At Anytime During Your Lifetime (check all that apply)

___Diabetes ___Depression ___Cancer (i.e., breast, cervical etc.)

___High Blood Pressure ___Anxiety ___STD (i.e., gonorrhea, Chlamydia etc.)

___Heart Attack ___Lupus ___Reproductive Problems/Infertility

___Stroke ___HIV/AIDS ___Substance Abuse (i.e., alcohol, drugs etc.)

___Arthritis ___Asthma ___Chronic Pain (i.e., backaches, headaches etc.)

Other Health Problems_____

_____

_____

Personal History of Depression

Have you ever suffered from depression?

- Yes
- No

Have you ever taken any type of medication for depression?

- Yes
- No

Have you ever participated in individual psychotherapy sessions for depression?

- Yes
- No

Have you ever participated in a support group to help with your depression?

- Yes
- No

Have you ever received spiritual guidance or religious support to help with your depression?

- Yes
- No

Do you feel comfortable talking with your primary care doctor about your personal problems?

- Yes
- No

Do you feel comfortable talking with a mental health specialist, such as a psychiatrist or psychologist about your personal problems?

- Yes
- No

Does anyone in your family suffer with depression?

- Yes
- No

What issues and/or concerns do you think may contribute to African American women that experience depression?

_____
_____
_____

What treatment strategies do you think would help African American women to cope better with depression?

_____
_____
_____

Beck Depression Inventory-II

This questionnaire consists of groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement that you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group.

Sadness

0 I do not feel sad

1 I feel sad much of the time

2 I am sad all of the time

3 I am so sad or unhappy that I can't stand it

Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself

1 I have thought of killing myself, but I would never carry them out

2 I would like to kill myself

3 I would kill myself if I had the chance

Pessimism

0 I am discouraged about my future

1 I feel more discouraged about my future than I used to be

2 I don't expect things to work out for me

3 I feel my future is hopeless and will only get worse

Crying

0 I don't cry anymore than I used to

1 I cry more than I used to

2 I cry over every little thing

3 I feel like crying but I can't

Past Failure

0 I do not feel like a failure

1 I have failed more than I should have

2 As I look back, I see a lot of failures

3 I feel I am a total failure as a person

Agitation

0 I feel no more restless or wound up than usual

1 I feel more restless or wound up than usual

2 I am so restless or agitated that it's hard to stay still

3 I am so restless or agitated that I have to keep moving or doing something

Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy

1 I don't enjoy things as much as I used to

2 I get very little pleasure from the things I used to enjoy

3 I can't get any pleasure from the things I used to enjoy

Loss of Interest

0 I have not lost interest in other people or activities

1 I am less interested in other people or things than before

2 I have lost most of my interest in other people

3 It's hard to get interested in anything

Guilty Feelings

0 I don't feel particularly guilty

Indecisiveness

0 I make decisions about as well as ever

1 I feel guilty over many things I have done or should have done

2 I feel quite guilty most of the time

3 I feel guilty all of the time

Punishment Feelings
0 I don't feel I am being punished

1 I feel I may be punished

2 I expect to be punished

3 I feel I am being punished

Self-Dislike
0 I feel the same about myself as ever

1 I have lost confidence in myself

2 I am disappointed in myself

3 I dislike myself

Self-Criticalness
0 I don't criticize or blame myself more than usual

1 I am more critical of myself than I used to be

2 I criticize myself for all of my faults

3 I blame myself for everything bad that happens

Changes in Sleeping Patterns
0 I have not experienced any change in my sleeping pattern

1a I sleep somewhat more than usual

1b I sleep somewhat less than usual

2a I sleep a lot more than usual

2b I sleep a lot less than usual

1 I find it more difficult to make decisions than usual

2 I have much greater difficulty in making decisions than before

3 I have trouble making any decision

Worthlessness
0 I don't feel I am worthless

1 I don't consider myself as worthwhile and useful as I used to

2 I feel more worthless as compared to other people

3 I feel utterly worthless

Loss of Energy
0 I have as much energy as ever

1 I have less energy than I used to have

2 I don't have enough energy to do very much

3 I don't have enough energy to do anything

Irritability
0 I am no more irritable than usual

1 I am more irritable than usual

2 I am much more irritable than usual

3 I am irritable all the time

Changes in Appetite
0 I have not experienced any change in my appetite

1a My appetite is somewhat greater than usual

1b My appetite is somewhat less than usual

2a My appetite is much greater than before

2b My appetite is much less than before

3a I sleep most of the day

3b I wake up 1-2 hours early and can't get back to sleep

3a I have no appetite at all

3b I crave food all the time

Concentration Difficulty

0 I can concentrate as well as ever

1 I can't concentrate as well as usual

2 It's hard to keep my mind on anything for very long

3 I find I can't concentrate on anything

Tiredness or Fatigue

0 I am no more tired or fatigue than usual

1 I get more tired or fatigued more easily than usual

2 I am too tired or fatigued to do a lot of the things I used to do

3 I am too tired or fatigued to most of the things I used to do

Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex

1 I am less interested in sex than I used to be

2 I am much less interested in sex now

3 I have lost interest in sex completely

Self-Esteem Scale

The following statements are concerned with how you may feel about yourself. Please rate each item by placing a number from 1-4 that best describes your sentiments, in the space to the left of each statement. The choices are as follows:

1	2	3	4
Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**

___I feel that I am a person of worth, at least on an equal basis with others

___I feel that I have a number of good qualities

___All in all, I am inclined to feel that I am a failure

___I am able to do things as well as most other people

___I feel I do not have much to be proud of

___I take a positive attitude toward myself

___On the whole, I am satisfied with myself

___I wish I could have more respect for myself

___I certainly feel useless at times

___At times, I think I am no good at all

Automatic Thoughts Questionnaire

Listed below are a variety of thoughts that just "pop" into people's heads. Please read each thought, and indicate how frequently, if at all, the thought occurred to you over the past two weeks. Please rate each item by placing a number from 1-5 that best describes your answer in the space to the left of the statement. The choices are as follows:

1	2	3	4	5
Not at All	**Sometimes**	**Moderately Often**	**Often**	**All the Time**

___I am no good

___I don't think I can go on

___I'm so disappointed in myself

___Nothing feels good anymore

___I can't stand this anymore

___I can't get started

___What's wrong with me?

___I'm worthless

___I'll never make it

___I feel so helpless

___Something has to change

___There must be something wrong with me

___My future is bleak

___I'm just not worth it

___I can't finish anything

Stressful Life Events Scale

Below is a list of statements about negative/stressful life events that can occur in a person's life. Think about the past year, and indicate how problematic the issue indicated has been for you during the past 12 months. Place a number from 1-4 in the space to the left of the statement. If you have not experienced the specific issue noted simply indicate N/A for not applicable. The choices are as follows:

1	2	3	4
Minor	**Low Moderate**	**High Moderate**	**Severe**

___Death of a child

___Death of a spouse

___Death of a parent

___Death of a close friend or relative

___Divorce/separation/serious marital problems

___Loss of a job/serious work problems

___Serious legal problems

___Serious housing problems

___Serious financial problems

___Serious personal crisis

___Serious trouble getting along with an individual

___Move to a new residence

___Physical attack/assault/injury

___Life threatening/serious illness

Social Support Appraisal Scale

Below is a list of statements about your relationships with family and friends. Please indicate how much you agree or disagree with each statement as being true, by placing a number from 1-4 in the space to the left of the statement. The choices are as follows:

1	2	3	4
Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**

___My friends respect me

___I can rely on my friends

___My friends don't care about my welfare

___I feel a strong bond with my friends

___My friends look out for me

___My friends and I are really important to each other

___My friends and I have done a lot for one another

___My family cares for me very much

___My family holds me in high esteem

___I am really admired by my family

___I am loved dearly by my family

___Members of my family rely on me

___I can't rely on my family for support

___My family really respects me

___I don't feel close to members of my family

Conner-Davidson Resiliency Scale

Think about your experiences during the past month and rate each of the statements concerning how you felt during the past 30 days. Please indicate your selection by placing a number from 0-4 in the space to the left of each statement. The choices are as follows:

0	1	2	3	4
Not at all True	**Rarely True**	**Sometimes True**	**Often True**	**True Nearly All of the Time**

___I am able to adapt to change

___I have close and secure relationships

___Sometimes fate or God can help

___I can deal with whatever comes

___Past success gives confidence for new challenges

___I can see humorous side of things

___Coping with stress strengthens me

___I tend to bounce back after illness or hardship

___Things happen for a reason

___I give the best effort no matter what

___I can achieve my goals

___When things look hopeless, I don't give up

___I know where to turn for help

___Under pressure, I focus and think clearly

___I prefer to take the lead in problem solving

___I am not easily discouraged by failure

___I think of myself as a strong person

___I make unpopular or difficult decisions

___I can handle unpleasant feelings

___I have to act on a hunch

___I have a strong sense of purpose

___I am in control of my life

___I like challenges

___I work to attain my goals

___I take pride in my achievements

Spiritual Well-Being Scale

For each of the following, please indicate your choice that best indicates the extent of your agreement or disagreement as it describes your personal experience. Place a number from 1-6 in the space to the left of each statement. The choices are as follows:

1	2	3	4	5	6
Strongly Agree	**Moderately Agree**	**Agree**	**Disagree**	**Moderately Disagree**	**Strongly Disagree**

___I don't find much satisfaction in my private prayer with God

___I don't know who I am, where I came from, or where I 'm going

___I believe that God loves me and cares about me

___I feel that life is a positive experience

___I believe that God is impersonal and not interested in my daily situations

___I feel unsettled about my future

___I have a personally meaningful relationship with God

___I am very fulfilled and satisfied with life

___I don't get much personal strength and support from my God

___I feel a sense of well-being about the direction my life is headed in

___I believe that God is concerned about my problems

___I don't enjoy much about life

___I don't have a personally satisfying relationship with God

___I feel good about my future

___My relationship with God helps me not to feel lonely

___I feel that life is full of conflict and unhappiness

___I feel most fulfilled when I am in close communion with God

___Life doesn't have much meaning

___My relation with God contributes to my sense of well-being

___I believe there is some real purpose in my life

Relationship Assessment Scale

Think about an intimate partner, mate, or close friend that you are in a relationship with. Circle a number from 1-5 for each item which best reflects your feelings and views.

How well does your partner meet your needs?

1	2	3	4	5
Poorly		**Average**		**Extremely Well**

In general, how satisfied are you with your relationship?

1	2	3	4	5
Unsatisfied		**Average**		**Extremely Well**

How good is your relationship compared to most?

1	2	3	4	5
Poor		**Average**		**Excellent**

How often do you wish you hadn't gotten into this relationship?

1	2	3	4	5
Never		**Average**		**Very Often**

To what extent has your relationship met your original expectations?

1	2	3	4	5
Poorly		**Average**		**Extremely Well**

How much do you love your partner?

1	2	3	4	5
Hardly at All		**Average**		**Completely**

How many problems are there in your relationship?

1	2	3	4	5
Very Few		**Average**		**Very Many**