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Attitudes and beliefs about mental health among African American older adults suffering from depression

Kyaien O. Conner[a,*], **Brenda Lee**[b], **Vanessa Mayers**[b], **Deborah Robinson**[c], **Charles F. Reynolds III**[a], **Steve Albert**[d], and **Charlotte Brown**[a]

Kyaien O. Conner: connerko@upmc.edu; Brenda Lee: belee@mhaac.net; Vanessa Mayers: vjones29@hotmail.com; Deborah Robinson: drobinson@pchspitt.org; Charles F. Reynolds: reynoldscf@upmc.edu; Steve Albert: smalbert@pitt.edu; Charlotte Brown: brownc@upmc.edu

[a] Department of Psychiatry, School of Medicine, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213, United States

[b] Mental Health America of Allegheny County, 1945 5th Ave, Pittsburgh, PA 15219, United States

[c] Alma Illery Medical Center, 7227 Hamilton Ave, Pittsburgh, PA 15208, United States

[d] School of Public Health, University of Pittsburgh, 130 DeSoto Street, Pittsburgh, PA 15261, United States

Abstract

Depression among older adults is a major public health concern leading to increased disability and mortality. Less than 3% of older adults utilize professional mental health services for the treatment of depression, less than any other adult age group. And despite similar rates of depression, African Americans are significantly less likely to seek, engage and be retained in professional mental health services than their white counterparts. Cultural differences in the way depression symptoms are manifested, defined, interpreted and labeled may in part explain some of these racial differences in help-seeking behaviors. Focus group methodology was utilized to identify and explore attitudes and beliefs about depression and mental health treatment utilization among 42 older African Americans who had recently suffered a major depressive episode. Thematic analysis of identified six overarching themes: (a) perceptions of depression, (b) the African American experience, (c) seeking treatment as a last resort, (d) myths about treatment, (e) stigma associated with seeking treatment and (f) culturally appropriate coping strategies. We discuss implications for practice, education and research.

Keywords

Aging; Depression; Stigma; Treatment

Depression is a common psychiatric disorder, affecting nearly 18.8 million adults, or about 9.9% of the U.S. population, in a given year (NIMH, 2003). Depression in the elderly is a major public health concern leading to increased disability and mortality for this population. Depression among older adults is widespread and is often undiagnosed and untreated. Eight to 20% of older adults in the community suffer from depressive symptoms and an estimated 6% of Americans aged 65 and older (roughly 2 million individuals) have a diagnosable depressive illness (Gallo & Lebowitz, 1999). By 2030, the numbers of older adults with depression will nearly double the current numbers, leading to an epidemic of depression

* Corresponding author. Western Psychiatric Institute and Clinic 3811 O'Hara Street, Sterling Plaza Room 245, Pittsburgh, PA 15213, United States. Tel.: +1 412 624 1318; fax: +1 412 383 5412.

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among older adults (Jeste, Alexopolous, & Bartels, 1999). These projections are largely based on the aging of the "baby boomer" cohort and greater life expectancy. Despite their high vulnerability to depression and other mental health conditions, older adults are much less likely than their younger adult counterparts to utilize professional mental health services (Bartels, Blow, Brockmann, & Van Citters, 2005; Cooper-Patrick et al., 1999; Dickey & Blumberg, 2002; Milazzo-Sayre et al., 2000; Zukevas, 2001). Less than 3% of older adults utilize professional mental health services for the treatment of mental health conditions, which is less than any other adult age group (Bartels et al., 2005).

Without appropriate mental health treatment, depression in older adults is often associated with significant distress, disability and impairment, including impaired quality of life, increased mortality, and poor health outcomes (Bartels et al., 2005; USDHHS, 1999). Related to the high rates of depression, older adults have the highest rate of completed suicide (USDHHS, 1999). With the numbers of older adults rapidly increasing in the United States, untreated mental illness among older adults is one of the most significant challenges facing the mental health service delivery system (President's New Freedom Commission on Mental Health, 2003), especially considering that the efficacy and effectiveness of both psychotherapy and psychopharmacology for late life depression have been successfully established (Administration on Aging, 2001; Blazer, 2003; Cole & Dendukuri, 2004; Reynolds et al., 2006; United States Department of Health and Human Services, 1999). In addition, previous research suggests that older adults are as accepting of depression treatments as their younger adult counterparts, and in fact prefer psychotherapy to pharmacotherapy (Arean, Alvidrez, Barrera, Robinson, & Hicks, 2002; Gum, Arean, & Hunkeler, 2006; Landreville, Landry, Baillargen, Guerette, & Matteau, 2001).

African American older adults suffer more psychological distress than their white counterparts due to their exposure to and experiences with racism, discrimination, prejudice, poverty, and violence (USDHHS, 2001); and many have fewer psychological and financial resources for coping with this stress than their white counterparts (Choi & Gonzales, 2005). One of the critical ways African American women cope with this daily stress is through their social support networks, which often include family, friends and religious affiliations (Davis, 1998). Unfortunately, as individuals age they are more likely to become distanced and isolated from these informal networks that once mediated their distress (Choi & Gonzales, 2005). Despite research which suggests similar rates of depression among African Americans and whites (USDHHS, 1999), racial disparities continue to exist in mental health service utilization. African Americans are significantly less likely to seek mental health services than their white counterparts. While only one-third of all individuals with a diagnosable mood disorder seek mental health treatment, African Americans seek treatment at a rate half that of their white counterparts (Brown & Palenchar, 2004; USDHHS, 1999). These disparities continue even after initial barriers have been overcome. African Americans attend fewer sessions when they do seek mental health treatment, and are more likely than their white counterparts to terminate treatment prematurely (Miranda & Cooper, 2004).

While African American older adults are less likely than their white counterparts to seek professional mental health services, they are more likely to utilize their informal support networks, the church and primary care physicians to seek help with mental health concerns (Administration on Aging, 2001; Cooper-Patrick et al., 1999; Snowden, 2001). Cultural differences in the way depression symptoms are manifested, defined, interpreted and labeled may in part explain some of these racial differences in help-seeking behaviors (Choi & Morrow-Howell, 2007; Lewis-Fernandez & Diaz, 2002; USDHHS, 1999). Unfortunately, however, members of individuals' informal support networks often lack training in dealing with mental health concerns, let alone geriatric mental health. Primary care physicians tend to rely on anti-depressant medication as the main treatment for late-life depression and are

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significantly less likely to refer older adult clients to mental health therapists (Fisher, Wei, Solberg, Rush, & Heinrich, 2003; Unutzer et al., 1999). Additionally, depression in African Americans is less likely to be detected in primary care than it is in whites (Borowsky et al., 2000). Given the disparities in help-seeking patterns and outcomes of African Americans, it is important to carefully examine the beliefs, attitudes, and expectations of the older adult African American community regarding mental health, the use of mental health service providers, and the utilization of mental health services.

Additionally, it is critical to be cognizant of the way in which depression symptoms present among African Americans whose expression of mental health conditions may be culturally determined (Carrington, 2006). Examining depression knowledge, beliefs and attitudes among African American older adults could provide insight into the expression of the symptoms of depression and the willingness to seek and utilize psychotherapeutic and pharmacologic mental health treatments. Patient beliefs about mental health need to be accurately identified, and care providers need to be aware and apply their knowledge of the impact culture has on the diagnosis and treatment of depression (Waite & Killian, 2008). Expanding our knowledge about African American older adults' beliefs about depression, its treatment, and the life circumstances that often influence their treatment-seeking behaviors may inform providers about the culturally meaningful perceptions of depression these clients bring to bear. Such knowledge could help frame treatment engagement and retention strategies with this population.

Method

Research design

We used focus group methodology to collect qualitative descriptive data to identify and explore the attitudes and beliefs about depression and mental health treatment among older African Americans who had recently suffered a major depressive episode. Qualitative methods allow participants to describe their experiences in their own words providing a unique perspective of the lived experiences of depressed older African Americans, and their relationship with mental health services. Data for this study came directly from the information provided by participants within four focus groups. These focus groups explored attitudes, beliefs, and social/cultural norms and values in a small round-table format. This group setting provided a forum which encouraged African American older adults with depression to disclose their personal experiences with depression, to reveal their attitudes and beliefs concerning mental health and seeking mental health treatment, and to brainstorm about strategies to more efficiently and successfully engage African American older adults with depression in mental health treatment.

Setting and participants

Participants were recruited from a community-based primary care center located in an urban, largely low-income and African American community within an Eastern city in the United States. A purposive sampling approach (Strauss & Corbin, 1998) was utilized to seek out and identify 42 African American older adults who self-identified as having a recent depressive episode. As this was a preliminary investigation into the conceptualization of depression in this population, we did not utilize any formal self-report or depression screening tool and we did not diagnose or confirm a depression diagnosis. A medical diagnosis of depression was not necessary for this investigation in which the purpose was to better understand how this group of African American elders, who self-identified as depressed, constructed their meaning of depression. Inclusion criteria included African Americans who: (a) were 55 years of age or older ($M = 65$), (b) self-identified as having experienced a recent depressive episode, (c) received primary care services from the

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community health center, and (d) were willing to share their views about depression in a confidential group setting.

Procedures

Before fully conceptualizing this project, the lead researcher (CB) met with the CEO of the community-based primary care center to begin a collaborative relationship and work together to identify potential needs of the community health center. We used community-based participatory research (CBPR) methodology to develop a research project that would benefit the older African Americans at the community health center, and that could also be generalized to help the African American community in general. The CBPR process was very time consuming as it took nearly six months to fully gain the trust of the community health center, and to identify and develop a comprehensive research plan. The focus groups discussed in this manuscript were seen as an integral first step toward the future development of a culturally competent intervention to help engage African American older adults in needed mental health services.

Research investigators met with the community health center staff and nurses to create a recruitment protocol that would be effective, not over-burden the clinic staff and be acceptable to African American older adults with depression, who are often mistrusting of research and may feel uncomfortable being approached by research investigators. The research protocol was determined to be exempt by the University Institutional Review Board. Clinic staff identified clients who were 55 and over and who, in their professional opinion, might be suffering from depression. Clinic staff received formal training over multiple sessions about symptoms of depression, with a special emphasis on symptom expression in African Americans, with the research team to maximize their ability to recognize depression in their patients. Clinic staff approached these clients while they were waiting to see their primary care physician in the client waiting room and gave them a brochure created by research investigators which outlined the purpose of our focus group, the process of being in the focus group, and the eligibility criteria. The brochure indicated that if the client had felt sad, stressed or depressed and endorsed a number of the symptoms of depression (e.g. trouble sleeping, trouble eating, feeling blue, concentrating etc.) that they may be eligible for the focus group, as this indicated a probable depressive episode. Clients were told that if they met the eligibility criteria and were interested in participating, that they could talk directly with a research coordinator if one was present (a coordinator was stationed at the community health clinic three to four days a week to talk to potential participants) or they could contact the research coordinator via telephone. If they did not meet eligibility criteria or were not interested in participating in the focus group, they were told to lay their brochure on the table as a signal of their decision.

The research coordinator reviewed eligibility criteria in more detail with potential study participants and arrangements were made for the focus groups. The focus group participants were also told the study purposes, procedures, risk and discomforts, description, and assurances of confidentiality. They formally agreed to take part in the focus group, maintain group confidentiality, and allow audio-taping of the session. Focus groups were held in a private room at the community health center. Transportation was provided to the focus groups for those who requested it. Focus groups were held between 10 am and 12 pm on Friday mornings, a time that met the needs of the majority of individuals. After obtaining verbal informed consent immediately before beginning the focus groups, participants filled out a brief demographic survey, and code-numbers were assigned to de-identify information (Table 1). Refreshments were provided for participants during the focus group and they received a $50 stipend for their time.

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Focus group discussions

Four focus groups were conducted with 42 participants. Each focus group contained nine to twelve participants. Focus groups were facilitated by the study PI (CB) and co-investigators (KC and VM), all of whom were African American females. Having African American facilitators seemed to have a positive impact on the dynamics of the focus groups. Participants identified feeling comfortable, and that they could be more honest and open about their feelings and beliefs. Each focus group lasted approximately 90 min and followed a semi-structured format. General beliefs about depression were elicited with several open-ended questions. Examples of general questions presented are: “What comes to mind when you hear the word depression?” “Describe the symptoms of depression.” “What causes depression?” The focus group progressed by asking more specific questions about their personal experiences with depression: “How can you tell when you are depressed?” “How has depression affected you at work, your marriage or relationship with partner, children, family or friends?” Focus group questions then began to target how participants chose to handle their depression: “How do you usually cope with depression?” “What treatment preferences do you have in coping with depression?” “What experiences have you had seeking treatment for depression?” Capturing African American older adults' beliefs about depression and depression treatments was essential to this study. Moreover, understanding how race impacted their beliefs and attitudes about depression and depression treatments was also critically important. Therefore, a question concerning their beliefs about race and depression was also asked, i.e.,: “How do the experiences of African Americans in this country contribute to depression in African Americans.” Probes were utilized by the facilitator to gain deeper understanding in to individual responses.

Data analysis

Qualitative techniques suggested by Zemke and Kramlinger (1985) were utilized to ensure the analysis was systematic and rigorous. The focus groups were audio-recorded and subsequently transcribed by a professional transcription agency and checked for accuracy. Thematic analysis was utilized to analyze the transcribed qualitative data. This qualitative data analysis technique entails developing themes and codes that are observed directly or emerge from the data being studied. Thematic analysis involves observing data, recognizing it and attempting to understand it through encoding and interpretation. The computer software program Atlas ti was utilized to support the organization and analysis of the qualitative data. This program aided in the process of coding the transcripts and retrieving thematically-structured and ordered-text segments. The thematic analysis process involved (1) producing a comprehensive inventory of important ideas, expressions, terms and phrases that reflect the language and views of participants, (2) generating categories under which identified ideas were placed, and (3) clustering the categories to identify broader themes and patterns that emerged from the data (Zemke & Kramlinger, 1985).

Transcript data were analyzed using in-vivo (line-byline) coding to categorize responses. Each line of text was read and assigned a code utilizing the respondents' own words. We utilized Atlas ti to organize these codes and develop a coding matrix. The PI and co-investigators independently coded the four focus groups' transcripts using the words of participants, and subsequently met on a weekly basis to discuss any differences in the codes assigned to the text and to attain agreement about the coding process style. After a thorough discussion about reasons for coding differences and correcting redundant coding, the research team came to an agreement about the coding assigned to lines of text and a final codebook was created. The final version of the codebook was utilized to re-code all the qualitative data. These codes were subsequently clustered to generate categories of data. Subcategories were constructed when needed. Categories of data were then combined to

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create over-arching themes and matrices were utilized to identify broader patterns and recurring themes across the four focus groups.

Findings

The focus group participants varied in age from 60 to 93 with an average age of 65 years old. Focus group participants were largely women (84%) who had been widowed. The majority of focus group participants had at least a high school education (79%) and a substantial number (48%) were currently retired or unemployed. The majority of focus group participants had recurrent episodes of depression, with many experiencing three or more episodes of depression throughout their lifetime. Only 33% of focus group participants reported having ever sought mental health treatment, and an even smaller 22% reported seeking mental health treatment within the prior 6 months. Responses and comments that emerged from the focus group discussions fit within the framework of six overarching themes: (a) perceptions of depression, (b) the unique experience of being African American that contributes to depression, (c) seeking treatment as a last resort, (d) myths about treatment for depression, (e) stigma associated with seeking treatment for depression and (f) culturally appropriate coping strategies.

Perceptions of depression

When asked “How you can tell when you are depressed,” focus group participants most frequently identified the clinical symptoms of depression. The most commonly cited clinical symptoms included: “sadness”, “not interested in doing anything”, gaining or losing weight, “problems sleeping”, “being tired and having little energy”, and “irritability”. Many participants noted physical symptoms such as “headache and body pains”. Other participants with histories of substance use and abuse identified wanting to do drugs, as well as excessive smoking and drinking as a signal that they were feeling depressed. Despite their ability to describe a comprehensive list of depressive symptoms, many participants discussed how difficult it was for them to initially recognize that these symptoms were part of the syndrome of major depressive disorder. Participants often felt that what they were experiencing was normal, and to be expected. One participant states: “I really didn't know or think I was depressed. You know, I think about, hey, this is normal. You got these kids, you supposed to go through this, and hey, you're a parent, you do the best you can and you accept, you know, what you going through”. Many participants stated that they had been going through a depression for a long period of time before acknowledging that they were in-fact depressed. One participant stated: “A lot of the time I think you can get depressed and don't recognize it. And don't recognize until it's too late. By that time they're into a deeper depression.” The difficulty recognizing depression was identified as a factor that kept participants from seeking professional mental health treatment.

When asked “What causes depression”, participants most often identified issues related to their relationships. Relationships between participants and their significant others, children, grandchildren, and friends were discussed at length. Most often however, the loss of these relationships through death (both natural and traumatic), conflict and divorce were identified as triggers of a depressive episode among participants. The majority of focus group participants identified loss as a catalyst to their depressive episode. Often the deaths were of “friends,” a “parent” or another family member. But the most difficult were deaths, sometimes violent deaths, of children. These deaths caused participants to feel alone in the world, and loneliness was identified a precursor to a depressive episode. One participant stated:

> “Uh, one of the things that affected me is the two children that died so close together, and left me with the one… It's a loneliness, too. You just feel like, I'm

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> almost in a world totally by myself. I been living by myself for over 50 years, and I never been lonely. And, sometimes I get thinking about what I wished I'd had done, and it gets to me, sometimes. And that's really depressing”.

For participants who were also raising their grandchildren, stress of raising small children was also identified as a cause of depression. Many participants were the guardians of small children, often due to the death of the natural parent or the inability of the natural parent to have custody of the children because of their addiction to drugs/alcohol or incarceration. While raising these grandchildren seemed to give participants something to live for and to look forward to, the financial, physical and emotional stress of raising children at an older age took a significant toll.

Older African American women also experience the stress of being a caretaker as a cause of depression. It was noted that among African American women, there is an expectation to take care of others, which often leads to the neglect of oneself. One participant states:

> “And I think another reason why people get depressed in my opinion, is we neglect ourselves. Particularly black people, black women. We don't have any good men to rely on. We've had children too early in life. And we neglect ourselves. We're so busy doin' for and trying to do the things that we should do and make up for it, we don't take the time to get our hair done, go to the spa, go get a facial, get a pedicure, ya know.”

Participants felt that their care taking role often made them feel like they were burdened with expectations that were unrealistic. Participants also felt that this role not only helped to cause their depression, but hindered their treatment seeking behaviors because they were so busy helping others that they couldn't help themselves. In fact, they didn't know how to help themselves. One participant states:

> “The hardest thing for me is knowing how to take care of myself… I'd been so used to, since I was a kid, taking care of everybody else”.

Another participant states:

> “Everybody thinks that I'm the strongest black, and that's another term I hate, Strong black woman. No I ain't! I'm not a strong black woman. I hurt inside. But people always depended on me.”

Many participants discussed physical illness and how medical conditions affected their mental health. Participants felt that the physical deterioration associated with getting older, and not being able to physically do the things they used to be able to do led to their depression. One participant stated:

> “Yes, the physical illness. Because I couldn't get up to do them things, you know. When you used to going to work and you all know that, you miss that. It's like, a piece of family goin to work, you know something that you wanna get up and go do. You know, because it's like a piece of you that you lose if you don't. When you do stay at home, what's you do{sick}, you just lay around”.

Other participants felt that the cause of their depression was simply due to their old age. Participants identified depression as a “normal” part of the aging process. The belief that depression often accompanied old age was another factor that led to deferred mental health service utilization for many participants.

The unique experiences of African Americans that contribute to depression

Participants also believed that being African American contributed to their depression. A commonly held view was that African Americans dealt with so much in society that they

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were more likely to be depressed than other racial groups. They felt that experiences of racism and discrimination tool a toll on their mental health. On participant stated: “I think, that black people do really have more reasons to be depressed because of our circumstances and the things that we have to go through that other people don't have to go through, other races don't have to go through. So we really have more reason to be depressed.” Another participant expressed a similar sentiment:

> “I know a lot of black people that's depressed. Every black person I know is depressed…We're born into a depressed (state). What we live with and adjust to…I have nothing against white people…But what we live through and go through… a white person couldn't handle it”.

Participants felt that even when African Americans recognize their depression, and want to get treatment, it is more difficult for African Americans to access mental health services than it is for other racial groups. Participants felt that this difficulty accessing services actually contributed and exacerbated their depressive symptoms. One participant stated:

> “These are things that we, I think, as blacks—we're not told about… If you make a phone call and they discover that you are black, then they transfer you to someone else, and by the end of the day, you don't wanna talk to anyone. You say, Forget it, I'll just sit here and keep it to myself… So we have to get information…by word of mouth from somebody else. We really don't get it from the professionals or the agencies or the people who (handle) it. We just get it from a friend. You know. And hopefully, you had a white friend to tell you”.

Participants also felt that the health education campaigns targeted at increasing the knowledge and awareness about depression were not effective in black communities. Participants largely believed that these advertisements were not targeted at them, and therefore they often disregarded them. One participant stated: “Well, if you look at television, for instance, and they bring the advertisement on depression medicine…I have it, and I'm not saying there isn't–I have not seen a black person. They're always um–always white. Yeah. I watch them myself”. Another participant expressed a similar concern about the absence of both African Americans and older adults in these advertisements:

> “And you know what, and basically I would say, they're in the younger group. You know, or they're either in a younger group or they're in a much older group. You know, it's like. Yeah. But I haven't myself seen it as a black commercial… a black person with depression”.

Participants felt that the media needed to do a better job at representing African Americans with depression in a positive way, so that those who needed help would be able to relate to the advertisements, and have a greater likelihood of actually seeking mental health services. One participant stated:

> “The media is what controls this city. And I really feel that more things need to be presented and the media needs to come with a more positive, more so than a negative, as far as black people are concerned, and this thing about depression. Everybody's not on crack. (you know) so okay, it's not that everybody doesn't wanna work, it's that people wanna work, but you can't find–you need like 5 jobs to pay for one, ‘cause they're all minimum wage. Okay, so, to me, it's more that… I really feel that more needs to be played in the media”.

Participants in general felt that racism still exists and that society continues to look down on African Americans. They believed that experiencing the stress of racism associated with being black in America contributes to depression in this population. One participant stated: “It seems to me it doesn't matter how you have to be but, still if you're black, you're still looked down on. To me, that's the way that I feel. I might be wrong. It's feelin' that way.

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And I don't know if I'm the only one that feels that way. But there are some of them that's nice. Don't get me wrong I'm not saying you know–but they still think they're superior. And they'll let you know, some of them will."

Seeking treatment as a last resort

The majority of focus group participants were not currently seeking treatment for their depression, nor had they ever sought professional mental health treatment for their depression. Many participants did not believe in seeking mental health treatment. They felt that it was a weakness, and that if you had true inner strength you wouldn't let depression get to you, and then you wouldn't need to get professional help. One participant stated: "There's things you can change, and there's things you can't change, but you need to have the wisdom to know the difference of what can be changed, and what can't be changed. And, in essence what I'm saying, to me, only things that can affect you or bother you, to put you in a down state of mind, is what you let bother you, and let affect you. Because if you don't let it, then it can't happen." Another participant stated:

> "We create our own depression…You say, oh, I'm depressed, let me go see the doctor. But some things you got to deal with. You know? From your inner self, you know. Spirituality or whatever, you got to deal with it. So you creatin' a lot of problems on yourself. Don't look for the Doc to find out a remedy. You got to work one out within. We lookin' for medication…mind-altering drugs, or somebody to tell us something. Rather than being a leader, we bein' a follower".

One of the male focus group participants spent a great deal of time talking about the difficulty of being an African American male and having depression and that considering seeking professional mental health treatment was not an option. He stated that African American men often don't get treatment for depression because they are not willing to accept that they are depressed. He goes on to state:

> "It's not that it's pride, it's that, you know a mans (not) supposed to be weak. He has to sometimes. Well, you know, a man's supposed to be the foundation of the household, which is the foundation of the community. And (put him in) an African-American setting (here)–look at our community, and the bottom line is everybody's gonna point not at the women, they're going to point at that man. I have a clear understanding of the fact that men get depressed. I just don't understand why they don't acknowledge it. Because they will not acknowledge it. That's another reason why we have so many men, number 1, using drugs. So many men leaving their wives. And (out) with other women. Because they don't understand what they're going through".

Other participants stated that they did not believe in mental health treatment. They did not believe in medical treatment in general. One participant stated: "I don't believe in too much doctors. I don't believe in going to the hospital that much either". Participants felt that mental health professionals could not be trusted, particularly mental health professionals who were white. One participant stated: "I used to go to a psychologist, years ago. You know when I stopped going? When I got mad at the therapist. I said, Why am I sittin' here telling this white man all my business? I know what's wrong with me, I know what I need to do. I'm out of here". Another participant expressed a similar sentiment.

Negative beliefs about white mental health professionals largely stemmed from participant perceptions about the mental health service delivery system, and how they have treated African Americans in the past. Participants also expressed concern about mental health researchers and how they use the African American community. One participant stated:

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> "Cause I'll tell you the truth. Since all the happenings in the 70s and all that, I really don't trust sessions. And that's bad. I know that's bad. So I got a prejudice against 'em in the first place. I think they're all full of it. Some people just want to write a paper…Uh huh…And I wish I didn't have that attitude. I really don't. 'Cause I am really enjoying sitting here. But I still had that attitude. I saw so many sensitivity bums during the 70s and all that. You know, you have a lingering suspicion. And I'm like, Well, if somebody's gonna write a paper, at least it's black folks gonna write it. And if other black people will read it, and benefit from it, then this focus group would be worth it".

Myths about treatments for depression

Many participants' decision to not receive treatment for depression stemmed from their beliefs about mental health treatment. Often these beliefs were based upon myths and cultural folklore, containing very little factual information. One myth identified by many focus group participants was the belief that mental health treatment was not effective at relieving depressive symptoms. When asked why she had not sought treatment for her depression, one participant stated: "I don't think that mental health treatment can help with depression". Another participant stated: "I don't think there is a cure for depression".

By far, however, the most frequently cited myth about depression treatment identified by focus group participants was the belief that anti-depressants were addictive and like street drugs. One participant stated: "For me, I think I would get get hooked on them. You know, 'cause I was gettin' the feeling I was getting' high. I already was gettin' high…I've tried a whole lot of things, that Prozac… none of that stuff worked… To me, it felt like gettin' high. So I just stopped taking it". Many participants stated that they were "afraid of taking medicine" to treat mental health conditions. In general, the majority of focus group participants did not want to take anti-depressants to treat their depression.

Even when a doctor prescribed an anti-depressant, participants admitted that they were not compliant. One participant stated: "My doctor gave me some, and I refused to take it. I got it up on my dresser". When asked why she did not take her prescribed anti-depressant, one participant stated: "I thought it was dope… I feel like, uh in my situation, I feel like I'd rather go to counseling with conversation and suggestiveness, rather than medication. And the medication that has been prescribed, some was even thrown away, I thrown it away". Participants often did not take their medications because they were concerned about the potential side effects. One participant stated: "I'm not very good at taking medication. Uh, I have a lot of side effects, and a lot of issues with meds. So I was very, very reluctant to take the medication".

Many focus group participants had legitimate concerns about taking another medication for an illness. Most focus group participants were over the age of 60, and many had a number of physical illnesses in addition to their depression. Participants were currently taking multiple medications for their physical health disorders, and did not want to take yet another medication. One participant stated: "I think I don't wanna take anymore pills. I'm already taking about seven a day. I won't wanna take more medication". Another participant expressed a similar concern: "I don't wanna take anymore medication. I'd rather talk, be with somebody you know".

Stigma associated with seeking treatment for depression

In addition to myths about depression treatment, many participants identified stigma associated with seeking mental health treatment. The majority of focus group participants stated that they had experienced stereotyping, prejudice or discrimination in their

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community based upon their mental health status. When asked whether she thought there was a stigma associated with seeking treatment for depression, one participant stated: “Yes. She coming out of the mental health building! She's coming out of the mental health building!” That's somebody she hadn't seen in a long time. And maybe she was in that building for something else, but she identified the sight with the woman she hadn't seen in a long time. And I thought, “Wow.” You know, so it's stigma. You know, just the mere fact that you came out of a particular place. People think you're crazy”.

Due to the stigma associated with seeking mental health treatment, many participants chose to hide their depression from friends and family. When asked if she was concerned about talking to her family about her depression, one participant stated: “As a matter of fact, I was laughed at in my family whenever I said I was going to see a therapist”. “A ha ha ha, going to see a therapist, that's wrong. Yeah. You know, that kind of thing. Which only hurt me. You know, that really hurt.” Participants identified stigma as barrier to seeking mental health treatment. Participants discussed that their fear of experiencing stigma and being identified as “crazy” led them to keep their depressive feelings to themselves. One participant stated:

> “Sometime when you think something's wrong with you… you don't really… I don't think you want to talk to anybody, because the first thing they say, “Are you crazy?” But if they don't say it, they look at you, and you look at them and say, “See, I shouldn't even talk to you, ‘cause you think I'm crazy.”

Another participant stated:

> “The first thing they say is “Oh, she's crazy.” Always acting crazy, you know what I mean? You don't wanna be referred to as crazy. You might want to be referred to as mentally ill, you know. ‘Cause mentally ill sounds more better than “Oh, I'm crazy!” You know what I mean. Oh, there's definitely a stigma”.

Participants felt that they did not have support networks that would be encouraging of their seeking mental health treatment for depression. Participants believed that their family members or friends would not understand what they were going through, and would be more of a hindrance than a support in this process. Participants stated that their family and friends often believed that depression “is a weakness. They think it's a weakness, and they think it's all right up in here. If your mind is right, you won't feel like that”. Families often told participants to just “Get over it” or to “Suck it up”. One participant discussed how he feared rejection from his family due to his mental health status:

> “I think that for men or women that it is first of all, maybe a fear of rejection, to go to somebody and say, “Well, I think I have a problem”. Whatever the reason, because I believe that stress-related depression comes about through life experiences. You know what I'm saying? Not enough money, kids are acting up, the marriage is in trouble…all those things contribute to stress, which can cause depression. And if I'm starting to become depressed and I need to go to my dad and say, I think something's wrong with me, I don't know what it is… I fear that he's not gonna understand. He's gonna think that there's something seriously wrong with me. Especially if I can't get to the exact nature. If I can't come to him and say, my bills is piling up, the kids are on my nerves, and I think I need some medication… he'll look at me like, you know… so a lot of people don't speak about it because they don't know how people will react to what they're saying. So it's a lot easier for me to keep it to myself as opposed to exposing it to somebody for fear that they're gonna look at me like I got some serious issues, or they're gonna reject the fact that there might be something seriously wrong”.

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Participants also believed that having depression and needing to seek mental health treatment was more of a stigma in the African American community than in other communities. One participant stated:

> "I think in black society depression is a stigma. And I think that it's because we make it a stigma. In the white society, when you're depressed, it's a status… symbol. Oh, what's your psychiatrist's name? You know…But, in a black society, I think we, as black women and black men, also, believe we are not to be depressed. We have overcome so many things, so why should we be depressed? We should always look back and see what our forefathers had paid the price, and we don't have the right to be depressed. And so, some of my children… They think I'm joking. They think it's a joke that, I [take Zoloft], "Oh, mom don't take no Zoloft. She's too strong for that." You know. And even my husband won't even admit that I take it. So, it's like a, "ooh, we can't admit that mom takes it." You know, so it's sorta "hush-hush" because, um… you know, black people don't do this stuff, 'cause we don't get depressed. So, it's like a, really… it's like you're out there if you take a depression medicine or if you're depressed".

Culturally appropriate coping strategies

Due to beliefs about depression, about seeking mental health treatment as a last resort, to myths about depression treatment and the stigma associated with seeking mental health treatment, focus group participants identified a number of culturally accepted coping strategies utilized to help deal with depressive symptoms. Participants often felt that in the African American community, black people "ain't got time for no depression." Therefore, participants often felt that they had to "deal" with their depression. One participant stated: "You learn to deal with it. You deal with it to the point where… I'm in this trough and I'm gonna stay in this trough. You know what I mean? You deal with it 'cause I'm gonna get out of here. I'ma get out of here." Another participant talked about how keeping mental health issues to yourself and dealing with them in the home is a cultural strategy that dates back to slavery:

> "I was raised by my grandparents, and my great-great grandparents, and their family before them, probably back to the slavery days… they never told what went on in the house. Everything was a secret, you didn't tell anybody. So it was passed down from generation to generation, whatever goes on in your house needs to stay there. "Well, why do we do it that way?" We just did it because. But I think that, now we're at a place where, as African American families, we need to open up and start looking at, Why are we doing this? We need to talk to the coming generations about what's going on so that they don't get caught up".

Due to participants' belief that they should be able to "deal" with depression, and that it will get better eventually, many participants coped with their depression by hiding it from their friends and family. This "frontin" was an effective coping strategy because it allowed participants to forget about their depressive symptoms, and kept their friends and family from labeling them as "crazy" and pushing them to get mental health treatment. One participant stated: "I don't… that's my problem, 'cause I don't talk to anybody. I'm always frontin'. I rarely tell anybody know how I'm feeling". When asked how he copes with depression, one participant stated:

> "A lot of people…like me… I wear a mask. You know, I could be depressed, but you would never know, 'cause I wouldn't tell you. Like, if I was depressed, and my kids— my son was around, he wouldn't know. Or my mom's around, and I'm depressed, you know, I could go to her and tell her how I feel, I would have a smile on, or I would tell her… I would tell her, Oh, I'm okay. Like, I feel that I'm a grown

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> man, I shouldn't go home and say, Mom, I need some help, or Dad, I need some help. But I knew every day, I looked out that window… that's the most depressing thing for me, just ‘cause I kept hiding. I kept hiding”.

In addition to learning to just deal with depression and hiding depression from family and friends, participants identified a number of other cultural sanctioned strategies for coping with depression. One strategy was to stay busy: “I just keep busy. I just keep busy–exercising, walking, and staying with a group of people.” Another participant agreed: “I just made up in my mind to keep myself from being depressed, not wait until I get really depressed, before I get into the depression, to try to keep myself busy so I don't get there.” Support groups were a popular coping strategy for the focus group participants: “I belong to several support groups. Uh, I had cancer, uh… 16 years ago now. And I belong to a support group so I can share any anxieties I have about that.” Another participant shard a similar strategy: “We have a grandparents' group' Cause I think support groups really are… a big help to people”. One participant identified using an on-line support group. She stated that this group provided the same support, in a less stigmatizing environment. When asked how this on-line group has been helpful, the participant stated:

> “They don't wanna patch you up. They's gonna tell it like it is, you know. What ever your problem is. Like if I tell them they'll help me with that problem. And I feels much better when you know they talk to me and I talk about it, ‘cause I'm able to say exactly what I wanna say…what's really bothering me. That's why I go to the chat room. And we talk to each other about anything, about everything. We just talk, talk, talking. So we both, you know feel better about it. I mean we don't pull no punches. We just go ahead and say what's really it is… no matter what it is. And I feel like everything done fell down off of me. I feel like somebody just came and took it away, you know. Then I get up and just go ahead and do what I gotta do. I can cope with anything in the world”.

By far, the most culturally sanctioned strategy for coping with depression was through prayer and the development of a relationship with God. When asked how she coped with depression, one participant stated: “Prayer. I go and shut the door and the best thing that twenty third psalm”. Another participant shared a similar strategy: “Yeah I um, prayers the first thing on my list”. Another participant stated: “I'll just say, God grant me the cure to heal the things I cannot change.” Some participants believed that it was actually through one's lack of faith that brought on their depression, and therefore the only way to beat their depression was to rebuild their faith. One participant stated: “Oh, put it in God's hands. Oh, go to your prayer closet. Oh, trust in God, don't forget your faith.” Another participant stated:

> “The reasons why depression was, like, swept under the rug was that, um, the fact it was thought that it would be a lack of faith. We were supposed to have faith that things would [get better] and we showed that we didn't…we were weak, or we had a problem. You know, you were supposed to take it to, you know, we do take it to the lord.”

Discussion and implications

This qualitative study examined the attitudes and health beliefs about depression and mental illness among older African Americans suffering from depression. Examining depression knowledge, beliefs and attitudes in this disadvantaged population provides insight into the perceptions of depression, expression of symptoms and the willingness to seek and utilize psychotherapeutic and pharmacologic mental health treatments of older African Americans. This study builds upon and validates previous work in this area which suggests African Americans create a language for depression rooted in their personal and cultural history and

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experiences (Black, White, & Hannum, 2007; Lawrence et al., 2006; Mills, 2000) and that African Americans are likely to not seek traditional mental health services (Diala et al., 2000; Miranda & Cooper, 2004; Snowden, 2001; USDHHS, 2001) and are more likely to utilize informal sources of care (Davis, 1998; Mills, 2000; Mills & Edwards, 2002; Warren, 1995). Specifically, our focus group interviews discovered that: (1) Older African Americans while able to identify symptoms and causes of their depression, often have difficulty recognizing their depression; (2) Being African American and experiencing racism and prejudice impacts the incidence of depression in the black community; (3) Even when participants recognized their depression, they often delayed seeking treatment until symptoms were extreme; (4) In addition to physical barriers keeping participants from seeking treatment, participants often endorsed beliefs about depression and depression treatments based upon myths and untruths; (5) Perceptions and experiences with stigma were high among study participants, and was a strong deterrent to seeking mental health treatment; and (6) Participants engaged in more culturally sanctioned strategies to cope with their depression symptoms. Overall, participants were now likely to seek professional mental health treatment. A thirty-three percent treatment utilization rate for African American elders is, however, high compared to most research studies (Miranda & Cooper, 2004; USDHHS, 1999). Our study sample is somewhat biased however, in that it is an entirely clinical sample, which may explain this divergence. All of our participants were attained from a primary care center, within which the majority of participants also received their mental health care.

The results of this study have implications for practice, education and research. This study suggests that older African Americans with depression endorse predominately negative attitudes about mental health treatment and mental health service providers. Study participants often did not believe mainstream mental health services would be effective, and therefore delayed help seeking and utilized culturally endorsed coping strategies for dealing with depression. This highlights the necessity of culturally competent providers and the importance of culturally competent care in general. Mental health care providers must receive consistent and ongoing training in cultural competency, and must be able to meet clients where they area, acknowledging the strategies they have been utilizing and building upon these strengths. Schools of psychology, social work and medicine must include more information about cultural competence and working with clients from diverse racial/ethnic backgrounds into coursework, and must work harder to actively recruit and train mental health clinicians of color who can serve as resources in the African American community. Increased cultural competency and the cultural relevance of mental health treatments may facilitate the type of positive experiences necessary to improve the image of mental health treatment in the African American community, and decrease the negative impact of stigma associated with seeking treatment (McCarthy, 2001; Thompson, Bazile, & Akbar, 2004). It is also important for clinicians to acquire more general skills that reflect their competency in working with African American and older adult clients. This study suggests that African American older adults have a high level of mistrust toward mental health treatment and service providers. This becomes particularly relevant when seeing a clinician from a different racial/ethnic group, or a clinician that is much younger. Since the majority of African American older adults who seek mental health treatment will likely have younger white service providers, it is necessary that these providers be aware of this issue and be skillful in their ability to elicit patient preferences, and discuss patient concerns, decrease stigma and be sensitive to the needs of this population.

This study suggests there is a lack of knowledge and understanding about late life depression among older African Americans and their families. Symptoms of depression were often viewed as a normal part of the aging process, and were viewed as being just another part of the African American experience. Participants felt that it was a weakness to

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seek professional mental health treatment and that they should be able to handle it on their own. This finding is consistent with numerous studies which have identified the tendency for African Americans, particularly African America women, to believe they need to be strong in light of significant stress and experiences of depression (Beauboeuf-Lafontant, 2007; Clark Amankwaa, 2003; Jones & Shorter-Gooden, 2003). Participants also believed that treatment for depression was not effective, and consistent with the findings of Brown and colleagues, that antidepressants were addictive and like “street drugs” (Brown et al., 2005). The irony is that the majority of participants felt most comfortable talking with their primary care physician about their depressive symptoms, the healthcare provider most likely to prescribe the very treatment they are averse to taking. Community-based health education interventions can provide accurate information about mental health symptoms and disorders in late life, effective mental health treatments, and how to access these treatments. Increased awareness and knowledge about mental health disorders and the availability and effectiveness of mental health treatments is fundamental to increasing older adults' service use (Choi & Gonzales, 2005). Such interventions can be effective for the general population and especially for racial/ethnic minorities. In the African American community, education campaigns should address common myths about depression and depression treatments, including the belief that seeking treatment is a weakness, and should be targeted for this community by using images and language that are culturally relevant and sensitive. For minority elders in particular, special outreach efforts are needed to reduce the fear and mistrust in the mental health system endorsed by this population.

Research is needed to further examine pathways to depression care for older African Americans with depression. Strategies and interventions to reduce barriers to care and engage and retain older African Americans in mental health treatment need to be developed and tested. We suggest the utilization of peer educators to bridge the gap between older African Americans and treatment engagement. Training peers to provide accurate education about depression and treatment, can improve attitudes about treatment and successfully engage vulnerable populations into treatment in a culturally sensitive and appropriate way (the development of a peer educator intervention based on of findings from the current study will be discussed in detail in a future manuscript).

The stigma about depression and about seeking mental health treatment emerged as a significant barrier to care. This study suggests that older African Americans with depression perceive and experience a great deal of stigma, and is consistent with other research suggesting that stigma adversely affects treatment seeking attitudes and behaviors as well as acceptability of mental health services (Brown et al., 2010; Conner et al., 2010; Conner, Koeske, & Brown, in press; Conner & Rosen, 2008; Corrigan, 2004, 2007; McCarthy, 2001; Sirey et al., 2001; Vogel. Wade, & Hackler, 2007). Therefore, in order to engage older adults in mental health treatment, it is necessary to identify strategies to reduce the stigma of receiving treatment. Research is needed to thoroughly examine individual experiences with stigma, and its impact on attitudes toward treatment, treatment utilization, retention, and treatment outcomes. Research should further examine the impact of multiple stigmas experienced by African American older adults who are suffering from depression. Participants often felt doubly stigmatized for being depressed, and for being African American. Stigma research needs to move away from addressing single stigmas and must begin to recognize and address the impact of multiple stigmas (e.g. age, race, mental health status etc.) experienced simultaneously on mental health treatment seeking attitudes and behaviors.

Limitations

The results of this study should be interpreted cautiously. The research study design was cross-sectional. Therefore, we were unable to capture different attitudes and beliefs about

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depression and seeking mental health treatment over time. Length of time dealing with depression as well as severity of depressive symptoms may affect individual perceptions of depression, seeking treatment, and experiences of stigma. Longitudinal data are needed to assess these changes. Lastly, given the purposive sample recruited for this study from only one primary health clinic in a small primarily African American and low-income community, these findings are limited in their generalizability to all older adults with depression, and may not represent the true proportionality or the total scope of issues in this population. However, given that there are few previously reported qualitative studies that examine the attitudes and beliefs about mental health among African American older adults, and even fewer that address issues of race and stigma, these findings represent an important step in identifying the relevant issues that can impact mental health treatment engagement and retention for this population.

Conclusion

Cultural differences in the way depression symptoms are manifested, defined, interpreted and labeled, as well as cultural beliefs and attitudes about seeking care had a significant impact on the help-seeking behaviors of African American older adults with depression. African American older adults were not likely to seek professional mental health treatment, and often engaged in culturally sanctioned strategies to cope with depression on their own. The decision not to seek treatment often stemmed from their cultural beliefs and agreement with myths about depression treatment, in addition to other barriers to treatment including mistrust of the mental health treatment system and perceptions of stigma. This research suggests that creative and culturally relevant interventions are needed to effectively engage and retain older African Americans in professional mental health treatment. Barriers to treatment utilization for this population such as lack of education about mental health treatment, mistrust and stigma need to be addressed.

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Table 1

Demographic and clinical characteristics *N* = 42.

Mean age	65
% Female	84
% > High school education	79
% Retired or unemployed	48
% Prior mental health treatment	33
% Treatment in past 6 months	22