Intergenerational Understandings of Black Women's Mental Health

Author: Jadeen Samuels

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by Jadeen Samuels

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Advisor: C. Shawn McGuffey, Ph.D.

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Abstract

This study delved further into the stigmatizing perception of mental health within the black community by focusing on its understandings in the population of black women. Black women statistically are underrepresented and underutilizing the mental health industry, so this study unearthed reasons behind these numbers through empirical research. From interviews with eight women from three generational cohorts (young adults, professional adults, and older adults), I examined their perspectives on the topic of mental health and how that may have changed over the course of their lives to where they are today. Findings concluded that factors such as sense of self for young adults, class and family socialization for professional adults, and older age acknowledgment for older adults shaped how these women understood the topic of mental health. For recommendations of how to further involve them in the industry, the women mentioned remembering impact of family and community; complexities of definitions of mental health; lack of inclusivity in the industry; and understanding different coping mechanisms as important factors. Despite generational groupings, these points can help researchers and practitioners better understand the reasons behind those statistics and help change the industry as a whole to include black women's voices.

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Introduction

Black Americans are 20% more likely to experience serious psychological distress in their lifetimes as compared to their white counterparts, but findings conclude that black individuals, even those who are higher-educated, are less likely to seek out mental health services than higher-educated white individuals (Hamm, 2012). Here we see how factors such as class do not create a difference in mental health outcomes for black Americans. While black Americans roughly account for 13% of the United States population (U.S. Census), this statistical disproportion shows how central their reduced involvement in the mental health industry is for their livelihoods. Historically, the topic of mental health is often scrutinized in conversations, but then why does this seem to go further based on factors such as race? The disconnect between black Americans' experiences of distress and professional-help seeking is crucial for professionals to understand how to effectively treat mental health amongst black communities. Within these communities, black women are overrepresented of those diagnosed with mental illnesses at 25% (Ward et al, 2009). Unlike their racial and gender counterparts, black women are having a uniquely intersectional experience due to racism and sexism in society (Spates, 2012), and thus with mental health care. More could be learned about the perception of mental health in black communities through the specific experiences of black women.

Negative or stigmatizing attitudes towards mental health subsequently may lead someone to not seek help or discuss their issues of distress, but what formulates this stigma? Experiences and processes of socialization inform how an individual may decide not to seek help in a situation of distress. For example, Hines-Martin et al (2009) found that "when family members or friends identified mental health services as a resource, over the course of time those services were sought out" (Hines-Martin et al, 2009). With regards to how these decisions are made, this show that a "persons' social relationships are important considerations in treating mental health

problems" (Kiecolt, 2008). Benefits may come in cases where people sought out services based on recommendations of positive outcomes (Hines-Martin et al, 2009), but what about those who have had no experience or negative outcomes? Even if people are not explicitly taught to stigmatize mental health, how can this understanding of mental health thus formulate stigma? Ward et al (2009) found that black Americans "sought services as a result of referrals by family members, and tended to seek treatment from ministers and physicians as opposed to mental health professionals" (Ward et al, 2009). Here, we see how generational attitudes shape an individuals' experiences regarding mental health, yet there is little information on how this impacts the socialization of subsequent generations.

Historical experiences occurring around a person's life also intersects with others who are the same age as them. Even though there are significant differences in their daily lives, the history that they are immersed in is nearly the same. This socialized practice is the concept of an age cohort (DiAquoi, 2017). In examining similarities and differences of black American women's definitions of mental health over the course of their lives, this study will be looking at different age cohorts. Life-course perspective theory helps examine the ways that different age cohorts' socialization around a particular topic can be examined throughout their lives. Raygine DiAquoi states that "in addition to the concept of the birth [or age] cohort, life course theorists have also given attention to the timing of their lives, of the life-stage that an individual occupied when they experienced a particular change, and linked lives or the way that life events can be experienced vicariously through one's relationships and networks" (DiAquoi, 2017). The transition of stages in the life-course can change our perception of certain events. With the idea of 'linked lives' scholars find that individuals within the same age cohort may be experiencing social phenomena in similar ways. Individuals' relationships and networks as well as their

personal biographies may also play a large role in their understanding of these experiences. Despite analyzing socialization differences between black Americans and white Americans, Mouzon concluded that "regardless of race, perceived support (the idea that help is available if needed) was found to have a stronger effect on mental health" (Mouzon, 2013). These social factors around a person were all parts of their perceived support networks, which ultimately affected their approaches to mental health throughout their lives.

In connecting life-course perspective theory with the topic of mental health, the statistical scale presented in Clarke (2011) summarizes that self-reported depressive symptoms drops significantly between early adulthood and raises again in older age. The next question becomes, what is causing this significant U-shape curve throughout most of adulthood? How may this statistic be similar or wavering for black American populations? Distinctions in experiences with mental health are also formulated from other experiences black Americans are predisposed to everyday, such as low socioeconomic status and discrimination. Other factors like cultural and familial stigma may also have multiplicative effects on poor mental health through cumulative inequality or cumulative disadvantage (Clarke, 2011).

This qualitative, inductive interview-based study provides a critical reflection for unpacking the stigma towards racialized mental health and how black individuals, black women specifically, internalize and interpret those messages in making decisions about seeking mental health treatment. What socialization processes occur? And do these processes change over the course of their lives and if so, how so? What can these conclusions tell us about the ways that black women may become a greater presence or consideration within the mental health industry? How can this active participation thus shape how the topic of mental health is socialized for future generations in the black community? In this paper, I first tackle the question of how

mental health has been socialized for black women in different generations. Then I address what these commonalities can tell us about factors that are most important for black women at different stages of their lives. Finally, I raise the consideration that the experiences of black women are not just seen as sharing stories, but rather give insight into ways that culturally-appropriate practices may help change community stigma and help-seeking behaviors. In examining the social worlds of black women, we can see how age shows intergenerational understandings of mental health and help shift intra-racial perceptions of it.

Literature Review

There is an expansive literature which examines the intersection of stigmatization, help-seeking treatment, and mental health in black American communities. Major themes include: 1) the different stages of one's life course, 2) how treatment is sought, and 3) how the ways in which culture, religion, and gender impact the experiences of black Americans with mental health. However, one gap in the literature that I found and address in my thesis study is the specific focus on black, professional age people (ages 25-50) and their experiences and attitudes towards mental health. With black female-identifying persons being 13.4% of the United States population (U.S. Census), this significant age group can be demonstrative of the experiences of black women today. While being a minority population in the United States, black women are overrepresented in the population of people diagnosed with mental illnesses at 25% (Ward et al, 2009). Many studies have focused on specific sub-groups' attitudes and experiences with mental health, but did not specifically discuss inter-group differences. Filling this large age gap may provide insight to black women's understandings of mental health, and how systemic-level and individual-level barriers (Ward et al, 2009) ultimately create this overrepresentation of diagnoses. Despite much work done in the field, we cannot forget that mental health is a

predictor of physical health for all. With stigma inhibiting one's understanding of mental health and approaches to therapy, this creates a greater at-risk population for health disorders and possibly death (Walker, McGee, & Druss, 2015).

Stages in The Life Course

Black children, young adults, and older adults are each at different stages in their attitudes, beliefs, and experiences with mental health and thus affects their strategies of treatment.

Children are a difficult population to study when it comes to their mental health service utilization because it is almost entirely not their own decisions to make. While their parents ultimately make the choice to address any mental health issues they may see with their child, this is still an important population to examine because these same health behaviors may be learned and reproduced in the following generations. Even when controlling for socioeconomic factors, it is found that black American children still have statistical associations between underutilization of mental health services and racial-ethnic identity (Slashinski, 2016). For these children and their parents, there are many barriers preventing their accessibility to these services. Some barriers include treatment attendance, compliance, accessibility and transportation to service providers, side effects of psychiatric medication, and family perception of mental health care services and providers (Slashinski, 2016). Greater structures of inequality impact these barriers that black mothers must endure and thus further forces the underutilization of these potentially impactful services, which then becomes normalized. Mouzon (2013) wrote that the "public policies limiting social services to Black Americans" serve as a structural-level barrier. Without having access to these services, this reinforces the idea that if any mental health issue with black children are "left untreated, [then] externalizing behavior problems in children [make them] more resistant to treatment" (Dempster, 2015). In an ethnographic study of black mothers, it was

found that the mothers' fears, struggles, and insecurities about how they could care for their children was a common theme in their narratives (Slashinski, 2016). Some other individual-level barriers for black American women include "internalized stigma of mental illness, shame and embarrassment about mental illness, lack of knowledge of mental illness and cultural norms" (Ward et al, 2009). With these aforementioned barriers working against them structurally, these mothers also held their own opinions, such as their distrust of state institutions and officials which impacted the underutilization of services for their children.

Even if one had no formal experience with any services in their childhood, attending college gives young black adults more opportunities to seek mental health treatment. Over the years there has been a growing number of college students with mental health concerns (McClain et al, 2016). However, once again it is found that literature often does not discuss the factor that culture plays in mental health issues (Campbell & Long, 2014). It is found that "black collegians have been found to report the least favorable evaluations of campus climates and endorse higher levels of race-related stressors, such as discrimination, which is a known predictor of negative psychological outcomes" (McClain et al, 2016) at predominantly white institutions (PWIs). As Chiang et al (2004) stated, minority students such as Black and Latinx students at universities tend to be more focused on their study skills and school grades, which leaves them little or no time to thinking about properly seeking treatment for their mental health. However, these stressors due to race and ethnic minority status along with everyday experiences of stressors in college are seen to "exert a negative influence on Black students' psychological functioning" (McClain et al, 2016).

The next stage that is looked at in the life course is that of elder black Americans. It is found that older black Americans have a larger burden of chronic illnesses and shorter life

expectancies which impacts their disparities in mental health issues (Wharton et al, 2016). Despite this, they are also less likely to seek formal services for their mental health. Instead, there is a "preference among older adults to utilize the trusted services of pastoral counseling over professional mental health services, [and thus the role of the] clergy [is] often [to] act as gatekeepers for more specialized and formal mental health treatment" (Wharton et al, 2016). Counteractively, as seen in Woodward et al (2010), the majority of the sample participants sought out formal mental health service care, but were all diagnosed with serious psychiatric illnesses. With potentially less serious mental illness such as depression, spirituality and religion are often sought as a treatment (Wharton et al, 2016).

Barriers Upon Seeking Treatment

The issue of mental health is not just a problem of reaching out for assistance but it also has to do with the help that is readily available. Looking solely at statistics, there is an imbalance between need and help-seeking for black women (Ward et al, 2009). The mental health discussion among black communities is a generational issue that stems back for a multitude of reasons. Historically, the sociopolitical treatment of African Americans in the United States has formulated a cultural mistrust towards the health care system (Ward et al, 2009). This cultural mistrust is defined as "paranoia, in the form of mistrust, of whites due to past and present experiences with racism and oppression" (Ward et al, 2009). While these historical barriers may not visibility still be in place, the internalized effects contribute to how non-visible barriers operate today.

Dempster (2015) talks about the fact that the disparity of black children not receiving mental health treatment is high. There is a disparity among adults in this community, and the same can be said for their offspring. This demonstrates the larger issue at hand when it comes to mental health, particularly for black Americans. However, there are many individual-level

barriers for black American families in terms of their ability to seek treatment such as lower socioeconomic status, the perception that treatment is ineffective, and the impact of family stigma.

The deterrence of the parents seeking help for their children stems from the concept of family stigma. Family stigma is a part of public stigma and "higher ratings of perceived public stigma are significantly more likely to avoid treatment for their own mental health problems" (Dempster, 2015). Another experience with public stigma is the way that black Americans are looked at with discrimination on an everyday basis. In their qualitative study on black women's barriers to mental health care, Hines-Martin et al (2009) found that "most [participants] experienced economic pressures, limited control over important aspects of their lives, and uncertain futures" (Hines-Martin et al, 2009). However, one aspect that "they did have control of was the persona they presented to others and the perception they held of themselves" (Hines-Martin et al, 2009). This public persona gave them the autonomy to potentially avoid mental health stigma in their social interactions. Dissimilarly, for a black family that may seek treatment for their child, they "perceive higher levels of stigma from others in their day-to-day lives when they are related to someone with mental illness even when they themselves do not attend treatment or have a diagnosable psychological disorder" (Dempster, 2015). In these situations, people are not judged as individuals, but rather for the familial groups that they are part of. Focusing on an elder black population, Woodward et al (2010) presents that public stigma may also be a barrier of seeking informal care networks. In their sample, "some residents may fear that exposure of any mental health problems and associated limitations would jeopardize their continued residence in public housing" (Woodward et al 2010). Many lived alone so it might be more widely known if they were unable to take care of themselves. Here we

see that the ways that we may be perceived and how we factor the opinions of others in our decision to seek help is a key issue behind why black Americans are against seeking treatment.

Chiang et al (2004) further develops this argument. Dempster (2015) had discussed the fact that children, when not receiving treatment for mental health become more resistant to treatment as they age. Chiang et al (2004) focused on the strategies of dealing with mental health for Black and Latinx college students. Black and Latinx students for the most part believe in "coping alone or keeping problems to oneself" (Chiang et al, 2004), instead of receiving professional help. These students, if not solving the problem themselves, mostly would prefer to utilize informal means of help. For Latinx students this meant turning to their families, as for black students this meant engaging more in religious and social activities. Both groups said their primary focus was their education, and as a result, they could not get professional help. Comparing these texts, we begin to see overlapping among the two points. We see that the college students were resistant to professional help, meaning we can infer that there is a high possibility they did not receive help as children from what Dempster (2015) proved. This means that as they continued to grow older, the more and more likely they would find alternative methods to coping with mental health issues, rather than seeking professional help.

This does not stop at college, but rather are just as prevalent throughout adulthood. The misconception of mental health help-seeking is that seeking informal sources of care may be as effective as formal sources (Hays, 2015). Some of these informal sources of mental health care are clergy, social services, family, self-help strategies (Woodward et al., 2010) (Ward et al, 2009). Although the National Survey of Black Americans (NSBA) showed that 43% of African Americans aged 18 and older rely exclusively on informal help (Woodward et al., 2010), not much literature has focused on how those informal networks are found. We see that throughout a

black person's life that a number of factors, including their environment, their parents' mental health status, and whether or not their parents sought help for mental health, play a key role in determining how resistant that individual is to treatment. However, a sample of black Americans aged 60+ living in public housing was found to be more likely to seek formal sources rather than informal sources of care (Woodward et al, 2010). This may be because there were more people with a serious psychiatric illness in the sample. It was also presented that "despite their higher use of formal than informal sources of care, over half (53%) of these public-housing residents in need had unmet needs for mental health care" (Woodward et al, 2010), thus making these people receiving formal treatment still a vulnerable population. This was a different perspective from what black women over age 65 in Ward et al (2009) shared. They found that these women compared to the other age groups "were the only participants to endorse exercise, physical activity, volunteering, and ongoing activity as important to coping" (Ward et al, 2009) with mental health issues. There are systematic disadvantages put in place to continue to push this agenda within the minoritized culture as a whole.

The Racialization of Mental Health Stigma

Exploring the everyday experiences of discrimination and its connection to mental health helps examine the ways mental health stigma has been racialized within the black community. As previously discussed there is a disparity in the need for treatment and treatment options (Alegria, 2008). The results that prove both racial and non-racial discrimination that black Americans face are "significantly and positively associated with all six mental health outcomes" (Mouzon, 2017) speaks volume about how culture plays a role in one's experiences of mental health. These six outcomes are: 1) lifetime mood disorders; 2) lifetime anxiety disorders; 3) any lifetime disorder; 4) number of lifetime disorders; 5) depressive symptoms measured on the Center for Epidemiological Studies-Depression scale; 6) serious psychological distress as

measured by Kessler 6 (K6) (Mouzon, 2017). Campbell & Long (2014) adds value to this importance of culture by showing how the intersection of one's identity as a racial or ethnic minority and their mental illness heightens their stigmatization in the world. Specifically, we see that stigmatization attached to mental illness is seen more in black communities because of culturally shaped beliefs on help-seeking, and treatment. Many people did not want to be "labelled" as crazy if they sought out professional services (Campbell & Long, 2014). In these spaces, the strategies of coping become trying to hide one's illness or avoiding any type of treatment. Results in this qualitative study found that race and culture impact the aspects of how one experiences depression. Within black culture there is a persistent fear of being labelled crazy if one identifies with a mental illness, such as depression. For example, as one participant mentioned with the 'strong black woman' trope, there is "a racializing and gendering of "crazy" and weakness" (Campbell & Mowbray, 2016). This shows how discussion of the topic of mental illness then becomes a taboo. Another impact of the stigma held within the black community and from others is the idea that "Blacks are not expected to be depressed" (Campbell & Mowbray, 2016) because of their strength of overcoming historical adversity, such as slavery and the Civil Rights Movement. While this can be argued as an ignorant statement, its message is one that has become an internalized belief for black people that they can cope alone (Chiang et al, 2004).

Black Cultural Experiences and The Role of Religion

Considering black cultural experiences is important to look at how one may understand the topic of black mental health. With the context of racial relations in the United States, "it is imperative that clinicians understand that incorporating ERS [ethno-racial socialization] into therapeutic practice is more than just providing culturally competent services, but that delivering messages about race are a matter of survival" (Reynolds, 2017) for black individuals. Cultural norms and beliefs are high barriers for potential treatment with mental health or illness as a result

of the types of referrals they may have received from family members or community (Ward et al, 2009). These cultural experiences are also impacted by external societal factors pushed into black communities. Specifically looking at those which affect black women, Ward et al (2009) found that "lower income, poor health multiple role strain, and the 'double minority status' of race and gender" were some societal factors which impact their mental health. However, this discussion of the importance of culture is often overlooked or simplified in clinical research discussions of black Americans and mental health services (Campbell & Long, 2014). Role of culture may serve as an "an environmental void that exists… in relation to information, support, and encouragement towards mental health service use" (Hines-Martin et al, 2009). When culture is considered as a social determinant, it also helps medical practitioners and researchers determine how certain health behaviors are constructed. In their qualitative study, Campbell & Long (2014) found that a common cultural misconception was the idea that black people do not get depressed. One participant shared that her mother explicitly deemed mental illness as something only white people could experience. Another cultural belief was that there should be a distrust of doctors and potential treatment. They believed that the doctors would simply try to overmedicate them instead of actually trying to treat their issue. They were also told that going to therapy was "for white people" (Campbell & Long, 2014). Participants in the study of Hines-Martin et al (2009) presented the view that mental illness was "all or nothing," signifying that there was no spectrum of mental well-being. Another cultural belief shared in Campbell & Long (2014) was that one should turn to religion in order to address any issues of mental health concerns. One participant mentioned that sometimes depression is not seen as a mental illness but an "issue of faith" (Campbell & Long, 2014). Culturally constructed beliefs such as these impacted how and if treatment was sought.

Historically being excluded from formal care services, religion was then used by black people as an alternative to dealing with issues of mental health (Campbell & Long, 2014) (Hays, 2015). However, there is not a clear line as to when it is appropriate to seek professional help. As discussed in Dempster (2015), there is a stigma associated with mental health and Wharton et al (2016) uses religion as justification behind why this stigma occurs. Understanding the systematic issues that black Americans face daily, and the use of God as a symbol of freedom, this contributes to the cycle of the misconception about receiving help about mental health. This also impacts their understandings of what mental health truly is. Although the sample viewed mental health and physical health as two separate entities, they did define that one's "spirit and physicality are intimately tied" (Wharton et al, 2016). Simple definitions like this serve as a barrier for a study found that black Americans aged 60 and over have a mistrust of the health-care system in general "for both cultural and experiential reasons" (Wharton et al, 2016), such as misdiagnoses (Hines-Martin et al, 2009). Furthermore, personal experiences in spaces like the church become places of "spiritual healing and rejuvenation" (Wharton et al, 2016). In these communities, not only is the church thought of in a religious sense, but also "black churches provide education, health resources, food services, economic support, and counseling to members, and the community at large" (Hays, 2015). Black communities were often comfortable with the church serving as a protective factor (Hays, 2015). This was also because to their there were consistent "concerns about formal care, issues related to trust, and issues related to credentials and training" (Wharton et al, 2016), as well as a belief that formal service environments were less welcoming and accessible by them. As this cycle continues, the informal mental health care services of church becomes engrained in the culture and becomes something of tradition.

Gendered Racialized Ideas of Black Women's Mental Health

There is now a greater discussion of the ways that approaches to mental health treatment is also impacted by gender. The literature of feminist psychology delves into the ways that mental health researchers and practitioners may be better equipped to engage with women patients. However, it is also important to consider the racial components that blackness adds to the way that mental health is approached for women. Using a black feminist theoretical framework, Spates (2012) argues that "black women experience unique stressors due to racism and sexism in the United States. However, again, there is a lack of empirically and theoretically based knowledge concerning this phenomenon" (Spates, 2012). Black women's overrepresentation in the population of people diagnosed with mental illness (Ward et al, 2009) directly shows how this lack of knowledge has consequences on their overall well-being. Not only are the mental health rates of black women uncertain because of a lack of research into that population (Spates, 2012), but Carter & Rossi (2012) also argue that there is an inherent belief that black women may not need mental health resources as much because they are too 'strong.' The image of the Strong Black Woman (SBW) is a stereotype that has found a way to control and dismiss the importance of black women's physical and mental health (Carter & Rossi, 2012). This ideology of black women having the physical and emotional 'strength' to endure the everyday struggles as well as the effects of multiplicative oppressions, puts their lives in a context of survival and not as human. Strength may be often conflated with resilience as they have made it for generations from "historic traumas preserving their self, family, and communities" (Black & Woods-Giscombe, 2012). The implications of the stereotype that SBW are always the care-giver (Wilson, 2001) completely eliminates them from the discussion of them being cared for. Carter & Rossi (2012) summarize this well when they say share that "strength as a monolith can be a damaging idea, and within the context of Black women's

strength, a stereotype of Black women's strength as emotionless, thick, self-sacrificing, and care-taking provides little flexibility for a healthy form of strength to include boundaries, self-care, expressions of sadness, depression, and anxiety which can lead to chronic illness" (Carter & Rossi, 2012). How are practitioners supposed to find ways to treat black women patients if there is no context to understanding their mental well-being? Although this is a cultural image of black women created from an oppressive white patriarchal society, the "missing blocks of fundamental knowledge in psychology concerning Black women coupled with the fact that racism and sexism are causing mental health problems paint a disturbing picture for Black women of the future" (Spates, 2012). In an attempt to begin a dialogue on how to fill those blocks, I chose to focus my study on black women.

Examining the way black women were socialized about mental health in this study, we can further understand this literature which examines the intersection of stigmatization, help-seeking treatment, and mental health in black American communities. Life-course perspective theory helps delve more into how age and generational groups make differences in approaches to mental health. These experiences of black women are not only life stories, but rather give insight into ways that culturally-appropriate practices may help change community stigma and help-seeking behaviors.

Methods

One significant gap in the literature about mental health is the longitudinal, comparative analysis of its effects across a black woman's life. This lack of connectivity does not give a full scope of what a black women's experience with mental health may be. It shows that there may be certain stages and occurrences in the life course where it is more significant than others. What can this tell us about the importance of looking at a black woman's life course holistically? A

longitudinal approach has the protentional to give mental health professionals the expertise needed to understand life and health outcomes on black women. As a first-generation, low-income, young Caribbean woman, this information was also vital for me to research and examine for myself and the black women around me. Not only is mental health most times approached with cultural stigma, but there is a significant lack of resources available for black women to even find forms of treatment. While 65% of the United States' psychology workforce is comprised of women, black/ African American individuals make up 4% of active psychologists as compared to 84% of white psychologists (American Psychological Association, 2018). While I have had my own conversations and experiences around mental health in my life, I found firsthand that it was reassuring to talk about with individuals who have been through similar gendered and racialized perspectives. As a black woman openly talking to other black women, I not only tried to address the gaps in the literature and field, but to begin facilitating an open dialogue to hopefully start enacting change in our community.

Participant Recruitment

In order to conduct my research and address the gaps in the literature, I conducted individual interviews with participants who agreed to participate. To be part of the study, each participant self-identified as a black woman and was over 18 years old. Each participant fell within a generational group of young adults (ages 18-24), professional adults (ages 25-50), or older adults (ages 50+). These groups served as age cohorts for my analysis. I aimed to have a quota of five interviewees per generational group. It is not known if any of the participants have any diagnosed mental health issues as they were not asked during the process of the interviews. I initially reached out to people who expressed interest in being in the study. From there, I actively snowball sampled by asking each participant if they could refer me to other people who may be interested in also participating. At the same time, I also made posts on social media such as

Facebook and Instagram to recruit more people. I conducted my interviews in person and by phone, so I limited my participant pool to the New York City and Boston Metro regions.

Participant Characteristics

Over the course of 4 months, I interviewed 8 participants. While they all spoke about being black, some women self-identified with their ethnic and national backgrounds. These cultural identities served great significance for some of the women in the narratives they spoke about in the interviews. However, they all discussed the shared racial experience of being black women. Their ages ranged from 21 to 51 years old. While originally having a quota that I wanted to achieve, the timeframe proved some difficulties. In my final sample, I oversampled for the professional generational group (N=5), which was a gap I aimed to fill with this study. Race and gender were the most significant factors in recruiting participants. They were aware that this study sought to talk more about their gendered and racialized experiences. Age was also a central factor with regards to recruiting my participants and in analyzing the data. The first significant factor regarding age for participants was that they were all over 18 years-old, per Institutional Review Board stipulations. Depending on each person's age, they were then placed in one of my three generational cohorts. Their ages were also used further on in my data analysis as these cohorts were central to my use of life course theory. Other factors like ethnicity, familial background, education, and locality, were significant for my analysis of each participant's interview. These allowed me to develop my comparative analysis about the different generational groups.

Participants demographics

Participant Name	**Age**	**Self-identified**
Lily	45	Black woman
Natalie	21	Caribbean-American, Black woman
Paige	27	Black woman
Julie	21	African-American woman

Lauren	51	Black woman
Chloe	25	Black woman
Diana	25	Black woman
Kelly	31	African-American and Haitian-American woman

Data

Interview Process

Whether I had contacted them or they reached out to me demonstrating interest in participating in my study, I explained my research question and more background on the topic I was looking into. Once participants agreed to be a part of the study, I conducted one-on-one interviews in a location of their choosing. Interview locations included personal residences, coffee shops, and the Boston College campus. From my point of contact with the participant physically or by phone, I followed the process of outlining the structure of the interview and the topics that we would discuss in an informed consent form per IRB requirements for human subject research. Throughout each interview, I followed a semi-structured interview guide tailored for their generational cohort. Most of my questions were positioned to be broad as to let participants control the narrative of the interview. The questions were tailored to follow the life course to see how their perspectives on mental health changed over time. This process allowed me to ask the same questions for each participant, but allowed the flexibility to change based on age and follow up on different points made throughout the conversation. The times of these interviews ranged from 10 to 45 minutes, depending on how much a participant shared on a question and how comfortable she was going further in depth on follow-up questions. As I followed my semi-structured interview guide, some participants wanted to expand further on topics raised, while some did not want to talk further about my follow-up questions. All interviews were voice recorded. I also took notes throughout. Afterwards, I transcribed the interviews and coded them to begin analyzing my data.

Interview Guide Questions

See Appendix A.

Analytic Strategy

The interviews were meant to get each participant to talk about their experiences with the topic of mental health from different perspectives which form the life course. The main point that I examined as a researcher was if each person's perspective on mental health and approaches to it had changed over different life course stages. After each interview, I transcribed and then found the ways in which these women described their perspectives on mental health and if their perspectives changed over different life course stages, creating macro-themes. Considering this data, I then created a chart with 20 coded themes (See Appendix B) that I found were significant in all of my interviews as a collective. I then went back through each transcript and macro-coded, or sorted through the codes that applied to the individual interviews. I then made a code map for each interview by including the codes that applied the most to each. After examining this primary data, I proceeded to microcode for each generational group by looking back at each transcript in order to capture any differences in common themes. Using life course and age cohort analyses, the data uncovered four significant themes for each generational group. With a small sample (N=8), each participant shared vastly different responses about their experiences and understandings of mental health over the course of their lives, but there were similarities on the topics each participant discussed at length. This is the reasoning behind why I chose to proceed by highlighting four particular ones which were applicable to each of the three generational groups. Following a similar methodology found in Chen (1999), I continued to present the data through the biography of a single respondent for each theme. I chose this analytic strategy to give light to the candid narratives these women took the time to share with me for this research, and not simply fit their life histories into a few coded topics. In providing

historical and situational contexts to how each of these individuals were socialized around the topic of mental health, readers could begin to uncover the importance of black women's experiences with mental health care. This also helps to learn more about mental health stigma in the black community as a whole. After presenting these general themes through four respondent interviews, I further analyzed my data on each remaining theme comparatively across generations looking for similarities or differences. This discussion is where the significance of the 'inter' in intergenerational is found. While each participant was at different stages of the life course, these themes help show that despite that, this interconnectivity is applicable to all.

Findings

From the interviews, four generational themes became apparent across the groups: sense of self, which is the perception that one has about their place in the world; class, which discusses the socioeconomic accessibility that one has; familial connections, which serves as one of the most important processes of one's socialization around mental health; and older age, which significantly shifted the ways that mental health was understood. These four biographies are archetypes of how these themes are relevant for each generation. They share the narratives of Natalie in the young adult generation, Chloe and Lily in the professional adult generation, and Lauren in the older adult generation.

Young Adult: Finding sense of self

"Seeing other people who were sad and depressed was kind of like a safe haven"

Natalie is a 21-year-old woman who is graduating from a four-year undergraduate university this year. She spoke with me openly about her transitions from childhood to her teenage years to becoming a more independent young adult living away from her home. On the ongoing journey of understanding of mental health so far, one constant that arose was about her

finding her own sense of self, or examining how she wanted to exist in world around her. Natalie defined mental health as a process of "taking a deeper look into how you feel, your emotions and how your mindspace feels". As we continued the interview, Natalie shared with me how her understanding of mental health evolved alongside her own sense of self as she progressed through different stages of the life course.

Her first encounters with the topic of mental health were through experiences with her father's anger problems growing up. These experiences distinctly made references in her mind of the "type of behavior [that] wasn't okay". This curiosity began to make some sense when:

> One time my mom was talking about why my dad is the way he is and she was talking about how he wasn't always angry and about how the death of his mom really changes and affected him… it was interesting to try to understand how that death could've maybe affected my dad to how he is as a person.

This significant event, which took place before she was even born, was one that completely shifted who her father was as a person and parent. Witnessing and experiencing this firsthand made her start thinking about mental health and how it could change with any momentous life adjustment.

In high school, one of these events took place for Natalie and impacted her sense of self. An incident that happened at school was put "in a Facebook group for our high school and everyone found out and everyone hated me and all of my friends who I thought were my friends kind of disowned me". She felt isolated and disliked by almost everyone in her social circle which developed her "own struggles with depression and self-harm" in what she recalled as "one of the darkest moments of my life". Natalie then reached out to her mother to talk about the situation that was taking place. While Natalie herself didn't exactly know what she was going through at the time, her mother also tried to intervene and "kept explaining it as, oh I don't want you to go to like a dark place". She mentioned that her mother was always a person to take

physical wellbeing seriously for Natalie and her younger brother. Particularly at moments that she felt a bit low, “my mom would give me vitamins… and health stuff… she went through that route, maybe not facing it head-on, but seeing if there are other ways to help it”. While she appreciated her mother’s openness to listen and help in ways she best understood, Natalie was still actively trying to figure out her own understanding of what she was going through with her mental health.

While her social circles at school and home were not always the best spaces to work on her finding her sense of self, she found a virtual community. She shared:

> I remember being on Tumblr a lot and following a lot of sad blogs, and I just remember being very very depressed… blogging about it and seeing other people who were sad and depressed was kind of like a safe haven for me, and because no one from my school really followed me.

Tumblr, a personal blogging website, was a space for N to talk about what she was going through with others who also were going through similar journeys. As she was still on this path to understand more about her mental health, it felt easier to do it in this space because “it was going into a world, but a world of people I didn’t know”. Eventually, she reached a point where she did not want to only live in this community and began to examine ways “to find happiness in myself and life again”. She found a love for creative media, including photography and modeling. These mediums helped Natalie “find a voice or an outlet” to express herself. In finding these tangible acts that she enjoyed, she started to find a newfound sense of self.

This continued when Natalie went away to college. In this space, both socially and academically, the “conversation about mental health became a lot more candid”. She made friends who would talk about their struggles with mental health issues very openly with the greater community which encouraged her to do the same. While she shared that her understanding of her own mental health deepened as she has gotten older, it’s still not something

that she feels overconfident it. Natalie mentioned "for me I smoke weed, so that's something that may be a coping mechanism so I'm not fully addressing it". However, she does think that learning to be more upfront with herself about these feelings and ways of healing are vital.

From the stories that she spoke about with me, sense of self or perception of how one chooses to exist in the world around them, has been an important aspect in her understanding of mental health has changed throughout different stages of her life course. In learning about how her father's sense of self shifted after that life-changing loss to finding community and acceptance online to thinking about ways to cope with negative feelings, Natalie's sense of self is constantly evolving. But it makes her proud to be on that journey of "realizing that I am enough for myself… healing myself… getting to know myself… seeing myself as a whole person".

Professional Adult: Class & Familial connections

"People are like oh she's a successful person who seems like she has everything together"

Chloe is a 25-year-old woman who works on a university campus. She recently completed her master's degree and in pursuit of completing a doctorate degree. Before sharing her personal stories around mental health, she first defined the concept as "generally a sense of wellbeing internally, emotionally, and mentally… may look like having a clear mind, a lack of distressing symptoms like feeling anxious or hurt or depressed or a general absence of negative feelings or thoughts. But for the most part like peace of mind and wellbeing". Though her experiences and understanding of mental health over the different stages of her life were vast, class has afforded her access to learning and speaking about mental health in ways that may not be the case for others.

Her exposure to learning about mental health began at a young age when her younger sister would attend therapy sessions. Although the rationale behind what those meetings were did

not occur to her at the moment, she later grew to comprehend its relation to mental health. For Chloe it was also a bit confusing to understand her place in those meetings because she "was there physically, but not really participating". Access to therapy was not really an oversight for her family growing up because her mother worked in doctor's office settings so there was "a lot of trust in doctors". However, for her parents there was a "disconnect between what you can't see, [and] physical health [which] is something that is very serious in my family". When it came to an immediate issue that arose around someone's physical health, there was quick action around that, but as it came to mental health as they saw with her sister "you can't say oh, it hurts here". It was still approached as something that could be overcome and that "you need to find ways to do what you need to do". Without there being much explicit conversation on the topic, Chloe developed some understanding from her situational context.

In entering the young adult stage in her life course, Chloe began to reach a much deeper understanding of mental health as an undergraduate in college. While this was a personal development, in her social life she "wasn't necessarily confident that my peers would understand that or cared about that. Or maybe they would have similar perspectives to my family". She shared that there was a slow progression of beginning to open up dialogue and become more comfortable "exploring mental health for myself". As she got older, Chloe did begin to share more about her mental health, but she knew they would accept as long as "there was a limit to it". She received positive feedback from her peers, but there was still a distance she felt that they had on the topic.

After transitioning in the stage of the life course, Chloe spoke about how this affected her ability to talk and think about mental health further in a professional setting. She shared:

> I'm in the field, so now I feel like it's my job to talk about it. I feel like I start those conversations a lot with people. I feel like the older you get the more

> experiences you have, the more people you talk to. I feel like at this point, my friends, and the spaces I'm in, the people I work with, there's more understanding about it, like in detail.

Working in the field of mental health had afforded her more opportunities to both learn and talk about her understanding and exploration of mental health openly. She shared that she was quite open to speaking with people about going to therapy as well. In reflecting on the access this openness provided her, Chloe told me,

> I'm able to do that based on the positionality I hold. People are like,' oh she's a successful person who seems like she has everything together, so you know, she's probably just going to therapy to do even better or like improve' rather than like 'oh there's something wrong'

The fact that conversations about mental health and therapy are able to be a part of her mundane conversations, provides her access to face less judgement or avoid thinking about stigma. However, this was an active decision in her choice of a career that she recognized. In thinking about these privileges of her class positionality, Chloe thought about:

> If I was someone outside of the field or like didn't have this education, I don't think I would be able to talk about it as openly or freely or I don't think I'd be able to be in an environment where people were talking about it as openly and freely. I think there would just be less understanding around mental health in general.

These opportunities that were presented to her because of her class identity allowed her to continue deepening her understanding of mental health in a more positive way. These intentional decisions that she took in her life, in navigating her interests and career, created these spaces as she got older as compared to when she was "actively trying to hide that in college". These accesses also helped her think critically about how her own perspective to mental health has changed over the different stages of her life so far. Chloe analyzed that "it's not just thinking about how your family plays into things… no, society plays into these things… this way as well and its influencing everyone else".

From her family's access and experience with child therapy, to entering a profession focused on mental health, Chloe's class background throughout the life course presented her with opportunities to think about and participate in understanding mental health more openly.

"Became self-aware because of the effects on my own family"

Lily is a 45-year-old Black professional woman with two children. For Lily, experiences with the topic of mental health within her family throughout different stages of the life course, have played a significant role in how she has developed her own perspective on mental health. In her definition of mental health as an "ailment of the mind," she comprehensively walks me through the timeline of how over the course of her life so far, she "became self-aware because of the effects on my own family". The significance of family was not only relevant for experiences she had throughout childhood, but in continuing onto her adult life in her career and amongst her newly formulated family.

Lily shared with me that there was no explicit definition or conversation when she was growing up about what mental health or mental illness was. However, she remembers evocative memories of different family members behavioral changes which she later realized were mental health related. For a period of time her grandmother drank alcohol heavily and her actions were both erratic and "an embarrassment for the family". It's not something they really discussed openly, but still something they knew was occurring. Eventually, her grandmother just stopped without any professional treatment. It was something "she kind of just overcame on her own". That was it. It was never brought up again. Lily recalled her mother also going through a similar experience of being extremely distant and sad in her childhood. Again, it wasn't something that was actively discussed, but her family members knew that there was something off. Without much change happening, at a certain point her maternal grandmother, who worked in the medical

field, took her mother to the doctor to seek professional help. These experiences happening so closely to her helped shaped the belief that one's struggles with their mental health "was something that you could shake".

As Lily got older, graduated college, started a family, and career, her perspective on mental health continued as a justification that "it's real, it happens, and we support that person, but it's not a dialogue". This lack of explicit conversation was also reflective of ways her family approached it as she was growing up. One event that began to open her up to learn more about it was a town hall on mental health that was hosted at her job. She was not able to find out how this event came to be or who originally suggested for it to happen, but she recalled that the facilitator was an African-American woman. Lily chose to listen and engage:

> I remember feeling like wow, it's amazing that people could expose themselves like that in a corporate setting, it's just so real… the people who got really personal about themselves, I was like woah… so interesting, so empowering.

Opening this dialogue up on professional level also allowed her to discuss more personal experiences in a different light with me.

More recently, Lily went through a difficult time dealing with the mental health of her daughter. Still living with more of a shake-it-off mentality, she shared that "even with my own child, I was kind of like, you'll be fine just give it time, you're a teenager, I've been through it, you'll get through it". Before realizing the severity of the situation that they were facing, she maintained the perception that as a teenager, one could "give it time" and "just dust yourself off". Recounting her first trip to the emergency room with her daughter, she said that she felt very resistant. It was challenging "as a black woman, I was listening to this white man doctor telling me about my child, like 'do you really understand what my child needs?' And he's telling me 'your child is asking for help and seeking out help'".

Now at 45-years-old, it has been a trying process but it has also helped "though time and prayer, I kind of learned to accept it". Coming from a generation where its normalized to tell others to give it time to get over issues. One of the harder things to consider is that this "ailment… it's tough because there's not a pill you can take to feel better". These experiences with her family, as a granddaughter, daughter, and mother helped shift her views on mental health throughout different stages of her life.

Older Adult: Age makes it easier

"I think because of my age, it is more acceptable for older people to address it"

Lauren is a 51-year-old professional woman who has two young adult children. She spoke with me about her encounters with mental health throughout her life growing up and into becoming an older adult. As it was not a topic that was not talked about as explicitly in her younger years, so one of the central aspects that she mentioned throughout her interview was that becoming older in age made the topic easier to discuss. Lauren defined mental health as "your stability with your emotions and depression and anything that makes you feel that you are unstable in your life". She was transparent with me about situations where she saw people have to deal with this instability, and about how those conversations became more normalized as they got older.

During her teenage years, she went through an eye-opening experience that made her begin thinking about mental health. One of her friends "was going through something and she took some pills". After her friend called her, they went over to her friend's house and told her mother. Recalling the memory, she said that "we went to the emergency room, we were teenagers, we were kids, but she had to go through some series of getting some help that way".

While she knew her friend had some problems, it was not until this incident happened that made her think about mental health and the effects it could possibly have on one's life if they did not know how to cope with it. Because her friend was hospitalized, "she was actually forced to get help". However, this made her think about behaviors within her own family.

Lauren shared that "in my family there was a lot of alcoholism and a lot of time where they had issues, it just wasn't talked about and they just turned to that to deal with their issues". Her first perceptions of mental health were these experiences of people using unhealthy ways to cope with these problems. She knew about people speaking to pastors when they may have had these problems, but for her family "we didn't go to church a lot, so that wasn't a thing that I did". In continuing this friendship with her friend who was continuing to get ongoing treatment, she learned more about mental health with her as they became adults rather than with her family.

As she got older, she developed a greater understanding of mental health and treatment through her friends in her generational group. This also brought up the racial differences in her understanding of it because most of her friends who were open about being in therapy were white. Lauren spoke about this further:

> In the black community, it's still kind of taboo… I think a lot of black people think it's a thing they have to deal with on their own… we internalize a lot of this stuff and turn to other sources for comfort… Black people are hesitant to tell a therapist who doesn't look like you their problems and that's still an effect.

Despite being in social circles where these discussions about mental health and treatment were more accepting, it was still important for her to realize the differences that race and cultural upbringing may have on approaches later in life.

While stigma may still play a role in talking about the topic in the black community, Lauren reflected that her older age made it easier for her and her friends to open up about mental health. One of the parts of their lives that also eased this was their discussion of their children's

mental health. As parents they may have seen behaviors which they then had to intervene on to protect their children's wellbeing. She shared that "I think it's still harder for teenagers to acknowledge that there is a problem". For her generational group, it became easier to recognize a problem and found ways to cope with it, such as therapy. She shared that this may be the case for her generational group today because "it's more out in the open now than when I was a child".

From her experiences in recognizing the importance of mental health treatment after the incident with her friend to seeing how that was beneficial in the long-term, Lauren felt that her older age presented more acceptable means "acknowledge that you have a problem and then address it". The significance of understanding these healthy and unhealthy ways to cope, which she saw with her friends and with her family, is the advantage that they can offer younger generations in their family in help them tackle their own issues.

Generational Differences

The short biographies of these four women reflect how the themes of sense of self, class, family socialization, and older age were archetypical for their generational groups as a whole. While each of my interviewees had completely distinctive life histories to share, their understandings of mental health as black women showed similar aspects based on how they related to other women within their age groups. With my small sample (N=8), I shared the chosen biographies because they most overtly spoke about these four generational themes, but I discuss further how other participants also spoke about them in similar ways.

Young Adult Generation

Natalie's story examined the importance of learning to understand mental health through the process of finding a deeper sense of self as a young adult. Her perspective of self throughout different stages of the life course shifted as she entered new spaces both physically and emotionally. Also, being a senior in undergrad, Julie shared how she "definitely became more

aware of taking care of mental health" once she got to college. Being in that space and away from home made her learn how to become "more conscious about how I'm doing and how my friends are doing". Similar to Natalie's experiences, being in this new space with people talking about the mental health more openly made her more introspective and curious as to understand her own mental health and gain greater sense of self in the world as compared to when she was younger.

Professional Adult Generation

Lily spoke a lot about how at her age, her understanding of mental health has shifted based on experiences she had with her family. Without the context of being socialized in these ways, she would not of held the concept of what mental health was and then think about how to approach it as she reached later stages of the life course. These socialized contexts were also brought up in Chloe's life stories. From her experiences with her sister's issues of mental health from a young age, she developed an idea which then made her think about it later on in life and also in her professional life in the field. Diana also shared about thinking about mental health through her sister who started having issues with depression after losing her job. Kelly opened up about witnessing a close family member who was diagnosed with bipolar disorder going through a psychotic break. That traumatic experience really helped shape her curiosity about mental health at a young age and then continued going forward into new stages of the life course. The families that one is born into and the families that one creates are some of the most fundamental forms of socialization that we may experience.

Chloe's biography discussed the theme of class in her understanding of mental health and how that affected the opportunities she has to approach it now in her profession. Lily also talked about this with her grandmother's knowledge and accessibility to get her mother professional

mental health treatment when she was young. As a professional adult, she also found herself working at a company who cared enough about the topic to facilitate a town hall focused solely on mental health. Accessibility, not only to treatment, but to open and honest discussions were very important to continue framing their perceptions of mental health through further stages of life. Kelly also talked directly about class and how her positionality with her friends, colleagues, and family allowed her to take advantage of actions like going to therapy. She shared more in depth about this experience:

> We have all attained degrees of secondary education… I think that matters a lot. I'm not gonna pretend that doesn't matter… My social networks give me a great deal of strength and really affirms me.

As a black professional woman, Kelly mentioned that her experiences with understanding her mental health were very tied to her privileges of class and education. Also mentioned by Chloe and Diana, the role that class plays in their social and professional circles are also microcosms of how they are able to think about their mental health amongst society at large. Being in this stage of the life course, these experiences change perceptions of how one looks at themselves and how others may view them. They all discussed the prevalence of stigma toward mental health in the black community, and how these privileges gave them different spaces to avoid it.

Older Adult Population

Given the limited time frame for completing my research, Lauren was the only person I was able to interview in the older adult generational group. However, the information that she shared with me about her and her friends' generational experiences reflected the important aspect of older age creating a new perspective of mental health. After going through other stages of the life course, they were able to learn and reflect on mental health and treatment. It was also helpful that they were able to do this collectively with each other as they became older. The topic and their personal experiences with it became more normalized and less taboo than when they were

younger. The community formed between Lauren's group of friends speaks about an intimacy that seemed quite unique to this generational group. While the understanding of mental health was more acceptable and brought less judgement from others, Lauren mentioned always considering the intra-racial stigma and treatment disadvantages that is still is occurring within the black community.

Discussion & Implications for Future Research

Examining the Inter- of Intergenerational

The narratives shared by this group of black women provides a lens of how mental health is looked at throughout different stages of the life course, particularly in such a globalized world. Generational differences are commonly acquainted with topics like utilizing technology, access to greater educational opportunities, and living through events of historical racial trauma in the United States. However, those lenses were not the only goals of this paper. The glimpses into these eight women's lives were to create a foundation for how to consciously think about the 'inter' in intergenerational. In Latin, *inter* translates to *among*. Regarding mental health, what is the common understanding *among* black women in different generational groups?

For the participants who agreed to be a part of this study, there was one common requirement regarding their identity: they were all black women. Despite generational group, age, or personal background, these women are all experiencing the same thing: existing and navigating society in the United States and the globe at large as black women. Regardless of the stage each is at in the life course, their "double minority status" (Ward et al, 2009) or racialized and gendered experiences that they each endure is vital to how the topic of mental health is being socialized among black women.

There were many similarities which were evident across all interviews and generational groups. From my macro-coding, there were four points that I found most important in beginning

to think about tangible steps that mental health professionals could consider as implications for future research to help move black women further into the field of mental health as professionals and participants:

i) Impact of family and community. Almost every woman mentioned the ways that their family's perception of mental health helped shape their own understandings of it from a young age and going forward to different stages of their lives. Not only families, but any type of social community that they happened or chose to be around, were reflective of their own views of mental health and treatment. This finding correlated with the finding that culture is a social determinant of mental and behavioral health in Campbell & Long (2014). These culturally-shaped beliefs impacted my participants' attitudes and help-seeking approaches. Recognizing the context that these spaces create can be the start of new conversations, which may in turn help reduce stigma concerns. Here were some points that spoke about this point:

   a. "Especially with my brother going away to school, I want to be in the position where I can make sure that he's talking to someone. You know being black, playing basketball, being tall… as a guy who doesn't talk about his feelings. I know that college is stressful as hell and I want to make sure that he's mental prepared for that" (Natalie, 21)
   b. "I have heard sometimes that when people are really connected with the church, they may speak with the pastor, but in my experience, we didn't go to church a lot so that wasn't a thing that I did personally" (Lauren, 51)
   c. "People who have problems with mental health will do see different specialists…religious specialists… as a result, you have a different sense of responsibility in the community to address a problem that may be an individual's condition, but then affects the larger community" (Kelly, 31)
   d. "Especially back then in Caribbean households you know something that you don't tell your parents, that you feel depressed… they'll be like 'what do you mean, be happy'" (Diana, 25)

ii) Considering the perspective that not everything is a mental health issue. This idea may come from the sociopolitical historical trauma that black people in the United

States went through, particularly with regard to the health care system (Ward et al, 2009). As the psychiatric profession became more of a mainstream discussion in the late 1800s, black communities were largely absent from institutional infrastructure and networks because mentally ill patients were put in segregated wards (Green et al, 99). Many participants talked about at some point of another of their lives thinking about mental health only in the most extreme of cases, but why may this be? Professor Martin Summers mentions that "the absence of a robust black psychiatric profession before World War II prevented the development of a 'psychiatry of everyday life' in the African American community, in which psychiatry was applicable to 'everyone, not only the patently insane'" (Green et al, 109). Here the sociohistorical implications of mental health care only being for clinically insane established racial community impacts. It is also important to consider the positionality of the respondents as black women and the risks that potentially being diagnosed with a mental illness may present in their lives. Some "risk factors include lower income, poor health multiple role strain, and the "double minority status" of race and gender" (Ward et al, 2009). Only recognizing or treating the extreme cases of mental health issues creates a perception that there is a greater difference between people who may be diagnosed with schizophrenia and those suffering from anxiety. This was similar to the finding that Hines-Martin et al (2009) examined in which "most participants clearly presented a view of mental illness as 'all or nothing'" (Hines-Martin et al, 2009). This in turn may be used as a tool to further the stigma towards mental health in general. Here are some points where my participants talked about this point:

a. "Not everything is full blown mental health, but sometimes you have to see and observe" (Lily, 45)

b. "When we learn about emotions in like kindergarten, happy and sad, do we immediately connect that to mental health? Does it make a difference if we're explicitly saying… it's important to know these things because XYZ, connecting to mental health instead of leaving it open" (Chloe, 25)
c. "I'm the type of person whose very optimistic like things will pass, you'll get through it and in that moment, I realized that not everyone has that mentality and it's something that's easier said than done and it took me a while to realize that anxiety is a real thing" (Diana, 25)
d. "There are gradations of mental health illness that I am beginning to realize… low functioning, medium-functioning, high-functioning" (Kelly, 31)

iii) <u>The mental health industry as it exists today is not inclusive for black women.</u> This discussion of inclusion for black women could be examined from a range of perspectives. It can be thought of in the numerical sense where we see that the number of black women participating in this industry as compared to the number of white women is very disproportionate. It may relate to the historical exclusion of all black people from the development of the industry separated from somatic diseases (Green et al, 109), which led to less culturally inclusive practices used in treatment. Thinking back to why black women are representative of 25% of the United States population with diagnosed mental illnesses (Ward et al, 2009), Hines-Martin et al (2009) shares: "health care providers' lack of cultural competence results in inadequate detection and recognition of mental health symptoms in African Americans, thus leading to improper diagnosis" (Hines-Martin et al, 2009). Another perspective that this non-inclusion can be viewed is the phenotypical representation of black women in the mental health industry. It is not very likely that someone would choose to participate in an activity like therapy with a person who does not look like them, and thus, may not find ways to relate to what they need to discuss. Here are some points that were made about this problem:

a. “A lot of black people think it’s a thing they have to deal with on their own and in thinking about outsource… there aren’t a lot of black professionals dealing with mental health so they wouldn’t be able to speak with them” (Lauren, 51)
b. “I went to a predominantly white high school and therapists were really big for my white peers, especially my white female peers” (Diana, 25)
c. “In these indigenous religious communities, a lot of people would say they [people diagnosed with schizophrenia] have a gift that needs to be cultivated and they need to be healed so that they then too can turn around the heal others… that’s why I feel we have so much to learn from other countries about how to deal with mental health” (Kelly, 31)
d. “She [a family member] had been misdiagnosed in her teens as possible having schizophrenia and they gave her Haldol, which is like an extremely intense anti-psychotic drug… that could’ve given her terrible problems” (Kelly, 31)

iv) Different coping mechanisms. Without the ability for people to recognize when something may be off with their own mental health, there is the likely chance that they will also not know the best ways to cope with it. This examination of different coping behaviors was also discussed in Ward et al (2009). Participants in that study “endorsed a range of coping responses such as seeking professional help; informal support from people in their support network or going to a community-oriented support group; religious coping; self-help such as reading, journaling, or having a positive attitude; and denial or avoidance of the problem” (Ward et al, 2009). Most of the women in my study mentioned processes like therapy and talking to people as ways to cope, but their mention of unhealthy ways that may mask issues are also quite relevant to think about. Some behaviors may not be culturally-specific, but they can help us see how different forms of treatment may be effective given different situations. Here are some points that some women shared about this:

a. “With my grandmother, it was an embarrassment for the family. But she fought that on her own. She found a way to cope and be better… It’s not something I ever asked her about” (Lily, 45)
b. “A lot of my family is overweight, and I know for my uncle because he lived with my grandma, once she passed away, he had a lot of physical health problems especially related to his weight. I always think about hos his depression or sadness

from my grandma passing away really made his physical health go down" (Natalie, 21)

c. "I see value in going to therapy, don't really see that it's effective, but it's nice to talk to someone because I like talking" (Paige, 27)
d. "I think the [phrase] 'I'm depressed' is overused… but maybe my roommate doesn't really know how to talk to people about it" (Julie, 21)
e. "I feel most times minorities try to deal with it on their own and they maybe turn to other sources like alcohol and drugs to maybe deal with the situation" (Lauren, 51)
f. "I do view it as a good thing and I think I originally thought that too because I went to those therapy sessions with my sister and nothing bad happened. It seemed like something positive was trying to take place" (Chloe, 25)
g. "Even I would see crazy people on the street, you know being from New York, you're used to crazy people on the street, but it's mental illness and they're not getting treated" (Diana, 27)
h. "I'm just very happy to see some of the friends in my circle taking it [attending therapy] seriously and prioritizing it as something they want to ensure they're addressing it on a continually basis… you know that gives me a lot of hope that out next generation, when we're having children, that it's something that we can introduce them to" (Kelly, 31)

Conclusion

As compared to their white counterparts, black Americans are 20% more likely to be diagnosed with physiological disorders (Hamm, 2012). While black American women are 13.4% of the population (U.S Census), they are overrepresented in the population of people with diagnosed mental illness at 25% (Ward et al, 2009). Using qualitative, empirical methods, I wanted to see how intergenerational perspectives may have shifted in today's society where certain topics are more open and less cliché. This paper found a new perspective to examining the topic of historically recognized stigma towards mental health within the black community: speaking directly black women about their socialization on mental health. Discussing each woman's understanding on this topic and how that may have changed over the course of their lives, gave more perspective to how their socialization is inherently intersectional.

Findings unearthed that for young adult black women, searching for sense of self, was an important factor in the ways they understood their own mental health and those around them. For

the professional adult cohort, class identity determined how they may have had access to thinking about and approaching mental health in their social and professional circles. One factor which also determined this was their experiences with familial socialization when they were younger. These experiences where reflective of how they thought about mental health should be approached or not, and in which ways. This finding delved further into family socialization as compared to the previous literature on this point: you grow up to reflect the perspectives of your family, but we never intentionally think about the ways this may manifest in as we get older. For the older adult group, I found that the older one gets and more experiences they have, the more others are open to accepting what they have to say. This positionality of age gave them a community to be able to discuss mental health with.

While this paper gave light to many new findings and continued to build on the previous literature, there were still some limitations. This study had a small sample (N=8) mainly due to the time frame of completing the thesis requirement. With a larger sample, more generational and cultural themes may have been uncovered and discussed further. The characteristics of the sample itself was also a limitation because it was not evenly distributed across the three generational cohorts. The professional age cohort was oversampled (N=5), and so more similar themes were found between those individuals as compared to the young adult cohort (N=2) and the older adult cohort (N=1). This professional cohort also incorporated a vast range of people and had the largest age gap between individuals (20 years). While they all were in the professional generational group, each person had gone through different stages of the life course. This cohort included some people who recently graduated from graduate school to people with a long-term career and had raised children. Despite this limitation, information on people in this

generational group (25-50 years old) was rarely examined in the previous literature, so this study started to filling that gap.

The narratives and themes found in this study also provided many benefits for the research about the black community's relationship with the topic of mental health and the industry. As many black communities' experiences with health care in the United States has been guided around "cultural mistrust" (Hays, 2015), it is beneficial to think about ways that perspective has or has not changed over time. For a population that is oversampled with diagnosed mental illness, black women statistically are underrepresented and underutilizing mental health resources. Talking to these black women about the ways they were socialized on an individual-level around the topic of mental health and treatment gives their voices a platform to potentially help shape better cultural practices in the industry. All of my interviews mentioned these four points to consider: remember cultural context of mental health in communities, idea considering that not everything is a mental health issue, the mental health industry is not inclusive for black women, and thinking about experiences of healthy and unhealthy ways to cope with mental health. The life histories and findings in this paper work against the erasure of black women in the field of mental health as practitioners and participants.

About the Writer

I was once told that I could not simply write about black women's mental health in such an important study without actively thinking about my own understanding of it. My first experiences that I can recall in thinking about mental health was associated with loss. I lost many close family members at a young age and I found myself and those around me going through bouts of sadness which I had never seen before. No one, myself included, sought any professional help. While I have never been clinically diagnosed, as I got older I realized that I have had periods of severe depression and anxiety. My main informal source of coping was self-help: writing and listening to music. They got me through some of the lowest points I had ever felt. As a young adult, my journey towards understanding mental health further began throughout the process of writing this thesis. The past seventeen months of conceiving, discussing, and writing about mental health with so many scholars, friends, and amazing black women has completely changed my perspective and approach. Writing this thesis was extremely dear to me because, in essence, it was about me, my mother, my grandmother, all of my ancestors before me and to come. I am particularly proud because this paper one of love.

Appendix

Appendix A: Interview Guide

1) Age Cluster 1: 18-24 Y/O
    a) Demographics:
        i) Age
        ii) Race
        iii) Gender
    b) How would you define mental health?
    c) What was the first experience/ occurrence/ encounter that you can remember with the topic of mental health?
        i) ONLY ON CLARIFICATION OR FURTHER EXPLANATION: Not necessarily with a person who has been diagnosed, but a discussion, etc.
    d) How would you say mental health is understood or perceived within your family?
    e) How would you say mental health is understood or perceived amongst your peers?
    f) How has your understanding of mental health developed throughout different stages of your life?
2) Age Cluster 2: 25-50 Y/O
    a) Demographics:
        i) Age
        ii) Race
        iii) Gender
    b) How would you define mental health?
    c) What was the first experience/ occurrence/ encounter that you can remember with the topic of mental health?
        i) ONLY ON CLARIFICATION OR FUTHER EXPLANATION: Not necessarily with a person who has been diagnosed, but a discussion, etc.
    d) How would you say mental health is understood or perceived within your family?
    e) How would you say mental health is understood or perceived amongst your peers?
    f) Being [INSERT PARTICIPANT'S AGE], how has your understanding of mental health developed throughout your life?
3) Age Cluster 3: 50+ Y/O
    a) Demographics:
        i) Age
        ii) Race
        iii) Gender
    b) How would you define mental health?
    c) What was the first experience/ occurrence/ encounter that you can remember with the topic of mental health?
        i) ONLY ON CLARIFICATION OR FURTHER EXPLANATION: Not necessarily with a person who has been diagnosed, but a discussion, etc.
    d) How would you say mental health is understood or perceived within your family?
    e) How would you say mental health is understood or perceived amongst your peers?
    f) Being [INSERT PARTICIPANT'S AGE], how has your understanding of mental health developed throughout your life?

Appendix B: Preliminary Codes for Interviews

Mental Health Macro-Codes
Stigma concerns
Familial concerns
Religion
Lack of information/ understanding on issue
Judgement
Lack of trust of medical field
Cultural barriers
Age
Time in history/ generation
Personal/ private discussion
Something that may be overcome
Never learned about it
Never discussed it
Family didn't talk about it
Family talked about it
Cannot happen to me
Only understood extreme cases of mental illness
Saw effects on friends
Saw effects on self
Saw effects on family

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