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# Barriers That Influence the Underuse of Mental Health Services by African Americans Diagnosed With Schizophrenia

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MS, Walden University, 2006

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Dissertation Submitted in Partial Fulfillment
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# Abstract

African Americans diagnosed with schizophrenia have longer wait times to be treated by mental health care professionals, resulting in their underuse of mental health services. This problem has motivated medical professionals to reexamine the ways in which services are rendered and then make appropriate improvements. The purpose of the study was to explore the lived experiences of African Americans diagnosed with schizophrenia and identify the reasons for their underuse of mental health services. A phenomenological research design was used to understand and explore the participants' lived experiences of the phenomenon. Participants were recruited from an independent living facility. Purposive sampling was used to recruit the sample of 3 African American men and 3 African American women who had been diagnosed with schizophrenia. Semistructured interviews were conducted using field notes and a digital voice recorder. Results of the content analysis supported the 5 themes related to the barriers that African Americans face when seeking treatment for schizophrenia: lacking transportation; feeling misunderstood by their doctors; perceiving themselves as being different, which they saw as a gift; trying to keep their illness hidden from others; and questioning whether they really needed to take medication. The 5 themes that emerged highlighted important aspects of the barriers that African Americans face when seeking treatment for schizophrenia. The results of this study will contribute to positive social change by informing health care workers of the reasons that African Americans do not seek treatment for schizophrenia and by exposing the need for increased awareness within health care organizations.

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# Dedication

I would like to dedicate this to my mother, Dorothy May Henley, who went to be with God on May 19, 2019, and to my sister, who left this life on January 11, 2011. My mom and sister were my biggest cheerleaders. My mom always said, “When you start something, make sure you finish.” I can still hear those words. I look forward to wearing that cap and gown, because this is for you, Mom. I know that you and Jacqueline will be with me in spirit.

# Acknowledgments

I want to thank my committee members for being so patient with me, for not letting me give up, and for making me think outside of the box. These scholars are an asset to Walden University, and I thank them for helping me to achieve my goal. I also want to thank my family for forgiving me for missing family gatherings because I had to complete my work.

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# Chapter 1: Introduction to Study

African Americans have been overdiagnosed with schizophrenia, and they have had to wait longer to receive psychiatric treatment (Lawson, 2014). Fleurantin (2013) reported that these factors have resulted in the underuse of mental health services by African Americans. Health care professionals have been motivated to reexamine the ways in which services are rendered so that they can make improvements. The National Alliance on Mental Illness (NAMI, 2015) reported that African Americans use mental health services less frequently than any other race. According to NAMI (2015), most African Americans diagnosed with schizophrenia have not received specialized treatment by their medical providers so that by the time they receive treatment (i.e., mental health services), their condition has worsened, which might be the result of their low socioeconomic status (SES; Lawson, 2014).

Fralich-Lesarre (2012) argued that many African Americans are at a disadvantage for receiving adequate mental health treatment because of low SES, lack of insurance, underinsured status, and cultural bias. Snowden (2012) reported that racial and ethnic minorities are less likely than European Americans to receive treatment for mental health disorders. Snowden asserted that when the aforementioned factors are held constant, along with the attitudinal differences between mental health providers and African Americans, significant barriers are maintained. Although Hispanic Americans and Asian Americans also are considered minorities, this study focused only on the underuse of mental health services by African Americans diagnosed with schizophrenia.

Lawson (2014) stated that the lack of understanding of African Americans' culture has led not only to disparities in mental health treatment but also misdiagnoses. These disparities in mental health treatment have resulted in disparate mental health services for African Americans (Snowden, 2012). Lawson reported that because of cultural differences, African Americans continue to be diagnosed with schizophrenia more often than European Americans are.

According to Hersen and Beidel (2012), negative, culturally based perceptions of African Americans by mental health professionals have added to the frequency of misdiagnoses. They also mentioned that instrumental barriers such as poor service accessibility and the lack of insurance have helped to maintain disparities in the provision of mental health services to African Americans. I used the terms *disparities* and *substandard services* interchangeably throughout the study to detail differences in the mental health treatment that African Americans receive when compared to the treatment that European Americans receive.

Fleurantin (2013) and Snowden (2012) suggested that racial and ethnic minorities in the United States are more likely to underuse mental health services or impulsively terminate treatment, despite the continued need for treatment. Addressing the barriers influencing African Americans' underuse of mental health services might help clinicians to find solutions. The findings might give health care professionals the opportunity to reexamine the ways that services are rendered and improve the ways that mental health services are provided to African Americans diagnosed with schizophrenia.

## Background

Insel (2010) emphasized that people with schizophrenia have differences in brain structure that include larger ventricles and smaller medial temporal lobes. Schizophrenia is not yet curable, so understanding the etiology and diagnosis of mental health in the African American community is essential to addressing the overdiagnosis of schizophrenia and the underuse of treatment. Baldwin (2003) suggested that disparities in health care emerged at the beginning of the 20th century, when only individuals in the middle and upper classes could afford advancements in medical and surgical procedures. In addition, Jim Crow laws that legally excluded African Americans from accessing or using medical facilities meant for European Americans only exacerbated the problem of poor mental health services (Baldwin, 2003).

Barnes (2008) and Metzl (2009) stated that race is a known predictor of being diagnosed with schizophrenia such that African Americans are more likely than their European Americans to be thus diagnosed. Snowden (2012) conducted research on mental health disparities in the African American community and confirmed the need to study the ways that community mental health centers function, particularly in diverse communities. African Americans are seen in hospital emergency rooms more often than European Americans for problems related to mental illness. Wilkins, Whiting, Watson, Russan, and Moncrief (2012) asserted that slavery; sharecropping; and exclusion from health care plans because of race, education, and social and economic resources have meant disparities in mental health care services to African Americans.

## Schizophrenia

In 1911, Bleuler (as cited in Burton, 2015) coined the term *schizophrenia* because the term *dementia* was misleading in that the disease did not always lead to mental deterioration; in addition, it sometimes occurred early in life. Bleuler (as cited in Burton, 2015) was the first researcher to describe positive and negative symptoms of the disorder. Schizophrenia is a chronic mental disorder that manifests as a breakdown in the relationship among thoughts, emotions, and behaviors, and leads to defective perceptions and inappropriate actions and feelings. Schizophrenia includes withdrawing from reality, including personal relationships, into fantasy and delusional thinking. Schizophrenia can be treated with medications and other interventions to reduce the symptoms. Schizophrenia is characterized by cognitive distortions, personality disintegration, affective disturbances, and social withdrawal. The American Psychiatric Association (APA, 2013) identified positive symptoms of schizophrenia in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) as delusions that are false beliefs about subjects, people, or situations.

Bleuler (as cited in Burton, 2015) noted that the term schizophrenia was derived from the Greek root words schizo (split) and phrene (mind) to describe the uneven thinking of individuals diagnosed with schizophrenia. He replaced the older term *dementia praecox* that had been used by Kraepelin in 1878 (as cited in Burton, 2015), who thought that the illness occurred only in young people; *praecox* means “very early.” To clarify matters, Bleuler changed the name of the illness to schizophrenia (as cited in Burton, 2015).

According to Burton (2015), even though Kraepelin had misguided beliefs about the onset of schizophrenia, Kraepelin was the first researcher to differentiate schizophrenia from other forms of psychosis, particularly affective psychoses that occurred in manic depression and mood disorders. Freud (as cited in Burton, 2015) had a profound impact on psychiatry during the 20th century. Freud’s influence led to the majority of psychologists in the United States agreeing that schizophrenia was the result of unconscious conflicts stemming from childhood (as cited in Burton, 2015). Since that time, researchers have confirmed that schizophrenia is a biological brain defect.

According to Amador (2010), people with positive symptoms can experience hallucinations with delusions, or they might hear voices telling them to take certain actions or warning them of imminent danger. Multiple voices also might talk to each other, warning the individuals not to trust others. Negative symptoms are more difficult to recognize and diagnose. Negative symptoms can include a disinterest in personal hygiene, social withdrawal, loss of motivation, and loss of interest in activities that once were considered pleasurable. Cognitive symptoms encompass problems with thought processes that can interfere with activities of daily living.

The U.S. Census Bureau (2010) reported a U.S. population of 318.7 million people, with approximately 42,163,000 of Black or African descent. The Census identified Blacks, or African Americans, as individuals having origins in any of the Black racial groups of Africa. This category includes African American, Black, Negro, Nigerian, Jamaican, and Haitian. The U.S. Census also documented that 19,057,000 African Americans are male individuals. NAMI (2013) reported that African American male individuals comprise 45% of the population and that in comparison to all women, European Americans, and all other ethnic groups in the United States, African American male individuals are diagnosed with schizophrenia more often by medical professionals.

Primm et al. (2010) suggested that African Americans are more likely than any other race to be diagnosed with schizophrenia. Lawson (2014) as well as Primm et al. reported that in spite of educational efforts and changes in diagnostic protocols, African Americans continue to be at risk of diagnostic mental health disparities. The misdiagnosis of schizophrenia can lead to unnecessary hospitalization, ineffective treatment, and adverse side effects of possibly unnecessary medication. Wilkins et al. (2012) noted that African Americans who are poor, are in jail, are homeless, or have a substance abuse problem are at greater risk of receiving poor mental health services. Untreated mental illnesses can result in disability and despair for families, schools, communities, and the workplace.

## Disparities in Mental Health Services

Primm et al. (2010) outlined disparities associated with mental health services for African Americans with schizophrenia, as did Snowden (2012). African American adults are 20% more likely than adult European Americans to report serious psychological distress. In addition, African American adults living below the poverty line are 2 to 3 times more likely to report serious psychological distress than those living above the poverty line. African American adults living with mental illness are more likely than adult European Americans to experience feelings of misery, despair, and unimportance. Lawson (2014) reported that 8.7% of African American adults, versus 16% of adult

European Americans, received mental health treatment between 2007 and 2008. Lawson also stated that 6.2% of African American adults, versus 13.9% of adult European Americans, received medication for mental health issues in 2008.

Alvidrez and Snowden (2009) asserted that African Americans have higher rates than European Americans of diagnosable lifetime disorders such as schizophrenia when they are seen in health care facilities. In addition, African Americans are seen in emergency rooms at a higher rate for problems related to mental illness. Omum (2012) discussed a study conducted by the surgeon general that was an extension of an initial study from 1981. The study was a 10-year follow-up examining mental health care provided to African Americans in 2001. Snowden (2012) highlighted several important factors from the study explaining why African Americans received mental health services disproportionately in emergency rooms as opposed to clinics. Factors included no medical insurance to pay for services, racial bias, and stereotyping.

The aforementioned factors showed that African Americans' mental health hospitalizations have been greater and treatment quality has been lower than for European Americans. Consequently, disparities in mental health might be limiting African Americans' access to preventative or primary care, meaning that when they enter the system, they are sicker than they should be. Substandard mental health treatment and the higher incidence of certain mental health illnesses have resulted in a lower quality of mental health outcomes for African Americans. Schwartz and Blankenship (2014) reported that 21.2% of African Americans who had been diagnosed with schizophrenia received minimal care, defined as appropriate medication management by a physician and eight 30-minute therapy sessions with a mental health professional.

Keval (2015) summarized a report released by the British Psychological Society and written by its Division of Clinical Psychology. The report, titled, “Understanding Psychosis and Schizophrenia,” documented the continued need for mental health service professionals to support effective action to ensure that clinicians understand the effect of schizophrenia. According to Keval, the article was an attempt to inform mental health professionals about the “many sociological and contextual factors that contribute to the social, cultural and political construction of ‘mental illness’ or ‘mental health’ ” (p. 1). Keval reported that concerns about the report were elevated because the authors of the report neglected to mention race and ethnicity.

Keval (2015) noted that an overrepresentation of schizophrenia diagnoses have been given to Black British and African Caribbean people. Race and racism continue to play significant roles in the diagnostic process and influence inequality in access to health care. Keval also argued that Black people are more likely than any other race to be diagnosed with a mental illness and labeled psychotic or schizophrenic. Keval contended that Blacks continue to receive unequal treatment from the mental health community.

## Summary

Included in the Background section was a discussion of the factors that have led to African Americans diagnosed with schizophrenia receiving substandard mental health services. The factors include their underuse of mental health facilities, their lack of trust in the medical community, the overdiagnosis of schizophrenia in members of the African

American community, and the stigma associated with the diagnosis. Researchers have agreed that increasing the awareness of African Americans' individual needs, comprehensively reviewing diagnoses, and eliminating bias expressed by the medical community might result in better clinical outcomes, thereby facilitating implementation of programs to encourage individuals to seek mental health treatment before they require hospitalization (Snowden, 2012).

The National Survey of American Life (NSAL, 2013) contended that African Americans are at a disadvantage to receive mental health services and treatment. The NSAL cited and reaffirmed the disparities in the surgeon general's (2001) report. Mental health care continues to be substandard for African Americans. The NSAL results showed that only 31.9% of African Americans diagnosed with mental illnesses receive treatment, as opposed to 41.1% of the general population with mental illness. The NSAL found this fact disturbing because chronic major mental health disorders such as schizophrenia are prevalent in the African American community.

## Purpose of the Study

Fleurantin (2013) conducted a phenomenological study of African Americans' underuse of mental health services and identified a knowledge gap concerning their lack of use of the services. Fleurantin suggested that more research is needed to bridge the gap in the mental health treatment of African Americans. The purpose of the current study was to explore the lived experiences of African American individuals with schizophrenia and identify the reasons for their underuse of mental health services.

Aggarwal and Mosca (2010) reported that nonadherence to antipsychotic medications has been associated with an increased number of hospitalizations of African American with schizophrenia, higher hospital costs, and more emergency room visits. Further study was warranted to explain the underuse of mental health services and nonadherence to prescribed medications by African Americans. Consequently, understanding the barriers to mental health services that impede African Americans from seeking and complying with treatment could increase the awareness of medical professionals of the need to implement programs to increase the use of mental health services by the African American community.

## Research Question

The research question (RQ; What barriers influence the underuse of mental health services by African Americans with schizophrenia?) was developed by considering previous research addressing the overdiagnosis of schizophrenia among members of the African American community. Anderson (2011) examined the lived experiences of African Americans men only; women were excluded from the study. Snowden (2012) conducted research into disparities in mental health services and the overdiagnosis of schizophrenia among African Americans. Fleurantin (2013) suggested the need for further research to increase the use of mental health services by members of the African American community. According to Metzl (2009), European American clinicians might, or might not, be aware of their biases. Snowden suggested that bias, lack of insurance, and cultural differences might account for disparities in treatment and the high rates of a diagnosis of schizophrenia among African Americans.

None of the aforementioned researchers examined the experiences of men and women living with schizophrenia. The RQ for the current study was designed to obtain knowledge of the ways the participants made sense of their lived experiences with schizophrenia (Creswell, 2003). Five interview items were designed to answer the RQ:

1. Tell me about a typical day.
2. Do you perceive yourself as being different from others?
3. How would you describe your treatment for schizophrenia?
4. How many mental health appointments have you missed, and why?
5. Have you had any negative experiences in treatment or trying to seek treatment?

## Theoretical Framework

The theoretical framework of this study was self-determination theory (SDT), which was developed by Ryan, Curren, Deci, and Waterman (2000). Mancini (2008) described SDT as a widely researched and empirically validated theory of human need and fulfillment. SDT focuses on the three basic human needs of autonomy, self-esteem, and respect. Motivation is a serious factor in recovery, but it has largely been ignored by researchers who have studied serious mental illness. SDT asserts that human motivation holds significant implications for mental health recovery.

Mancini (2008) described two types of motivation: internal and external. Internal motivation refers to the essential need to seek out challenges to extend and exercise one’s capacity to explore and learn. Internal motivation is the highest human capacity because it involves the need to explore surroundings and express an interest in the environment.

External motivation also is important to the recovery process. Motivation involves behaviors meant to achieve a positive outcome or receive a reward. For example, a person with a mental illness might take medication just to comply with external pressure or might really believe that taking the medication is helping to achieve life goals.

## Method

Creswell (2012) argued that a phenomenological research design offers a flexible and available approach to understand the lived experiences of human behavior. I used this approach with the intention of giving the participants the opportunity to express in-depth accounts of their experiences with schizophrenia. Biggerstaff (2009) outlined the ways in which this approach can give researchers the opportunity to develop an idiographic understanding of their participants' lifestyles and environments within their social realities. According to Creswell, a phenomenological approach allows researchers to study the participants' personal lived experiences. "It produces an account of lived experience in its own terms rather than one prescribed by pre-existing theoretical preconceptions, and it recognizes that this is an interpretative endeavor as humans are sense-making organisms" (Creswell, 2012, p. 181).

## Nature of the Study

I followed a phenomenological, qualitative approach to explore the feelings, beliefs, and attitudes of a sample of African Americans diagnosed with schizophrenia to understand their underuse of mental health services. I used SDT to explore the participants' experiences of living with schizophrenia. SDT reflects the internal motivation, not the external influences, for the choices that people make. The results were based on the participants’ responses to interview questions about their experiences living with a diagnosis of schizophrenia and their concomitant underuse of mental health services. The gap in the literature has resulted in the failure of researchers to identify the reasons for the underuse of mental health services (Fleurantin, 2013). According to Snowden (2012), African Americans continue to be diagnosed with schizophrenia at higher rates than those of European Americans.

To be in the study, the participants had to have been diagnosed with schizophrenia and had to have been hospitalized several times for schizophrenia within the last 5 years. The results of the study might help to increase African Americans’ use of mental health services to treat schizophrenia while reducing the number of misdiagnoses of members of the African American community. Bringing awareness to government policymakers about the social injustice in health care and the ways that services are delivered also might generate positive social change.

## Definitions of Terms

*Alogia*: A term used in psychology to reflect a lack of personal content in speech or conversation; also referred to as poverty of speech, meaning that the affected individual uses only the bare minimum number of words needed to communicate (*Oxford Dictionary*, 2017).

*Biologic etiology:* A branch of medical science dealing with the cause and origin of disease relating to the brain (Tamminga & Medoff, 2000).

*Epoche:* The state where all judgment about nonevident matters is suspended (Creswell, 2007).

*Hyperlipidemia:* An abnormally high concentration of fats or lipids in the blood (American Heart Association, 2015).

*Idiographic:* The study of the individual, who is seen as a unique agent with a unique life history, with properties setting the person apart from other individuals (Conner, Tennen, Fleeson, & Barrett, 2009).

*Medication adherence:* The degree to which a person agrees with the recommendations of a health care provider (Jimmy & Jose, 2011).

*Metabolic syndrome:* Risk factors that raise the risk of heart disease and other health problems such as diabetes and stroke (Mayo Clinic, 2013).

*Myocarditis:* Inflammation of the heart muscle (Liu, Liu, Liu, Yang, & Kwong, 2010).

*Nonadherence:* Noncompliance with medication regimens that can include not having a prescription filled, taking the wrong dose, taking a medication at an incorrect time, forgetting to take a dose, or stopping therapy prematurely (Ghimire et al., 2015).

*Phenomenology:* The essence of human experiences concerning the phenomenon under investigation, as described by the participants in a study. Phenomenology encompasses the study of structures of consciousness experienced from the first-person point of view (Creswell, 2007).

*Residual symptoms:* Long-term negative symptoms of schizophrenia, with positive outcomes such as hallucinations and delusions disappearing or being reduced in severity or frequency (Weiten, 2002).

*Schneiderion:* Symptoms indicating that a diagnosis of schizophrenia is likely, provided that organic or toxic causes such as delusion of control, thought withdrawal, and insertion broadcasting are ruled out; can involve hearing one's own thoughts spoken aloud and hallucinations, in which two voices carry on a conversation (APA, 2013).

*Tardive dyskinesia:* A neurological disorder characterized by involuntary movements of the face and jaw (APA, 2013).

## Assumptions

I assumed that the study would help to bridge the gap in the literature concerning the barriers influencing the underuse of mental health services by African Americans diagnosed with schizophrenia. Wilkins et al. (2012) noted that African Americans who are poor, are in jail, are homeless, or have a substance abuse problem are at greater risk of receiving poor mental health services. Untreated mental illness can result in disability and despair for families, schools, communities, and the workplace, not to mention huge costs for state and government agencies. According to Creswell (2003), qualitative researchers make methodological assumptions. The procedures that I used, as described by Creswell, were inductive and were based on my own research experience collecting and analyzing the data.

## Scope

Cognizant or incognizant bias demonstrated by clinical staff, along with a lack of cultural competence, can lead to misdiagnoses and inferior quality health care for African Americans. I interviewed a sample of African American men and women between the ages of 18 and 70 years. Snowden (2012), along with other researchers, outlined the disparities in mental health services provided to African Americans. I designed the study to identify the barriers influencing the underuse of mental health services by African Americans diagnosed with schizophrenia.

## Limitations

Limitations associated with a qualitative approach are related to validity and reliability. Qualitative research occurs in the participants' natural setting, making it difficult to replicate previous studies. This study had two limitations: One limitation was the small sample size, and the second limitation was the requirement that the participants had to live in the community where the study was conducted.

## Significance

There has been a lack of qualitative research examining the underuse of mental health services by African Americans diagnosed with schizophrenia. According to Snowden (2012), mental health professionals lack knowledge of the coping strategies used by African Americans to deal with mental illness. This lack of knowledge has forced African Americans with schizophrenia to seek informal support from their local church congregations, family members, and friends to help them to meet their mental health needs. The gap in research concerning the underuse of mental health services in the African American community remains (Tarman, 2015).

Copeland et al. (2015) reported that "mental health literacy about schizophrenia is very low. Patients and families tend to engage in denial and ignore symptoms, and many mental health providers have limited knowledge of schizophrenia" (p. 57). Mental health professionals must be prepared to amend their practices to meet the needs of all individuals with mental illness. I sought to elicit information from the African American participants about the reasons for their underuse of mental health services. Results might provide clinicians with information about ways to increase mental health services and support interventions that can help African Americans diagnosed with schizophrenia to understand the importance of complying with psychiatric protocols and addressing any nonproductive coping skills.

## Summary

Schizophrenia is a chronic and disabling mental disorder. Individuals diagnosed with schizophrenia demonstrate poor insight about their illness, and they have a diminished ability to focus and use information learned in their everyday lives. The results of this study might help bridge the gap in literature concerning the underuse of mental health services by African Americans diagnosed with schizophrenia. The findings also might improve their lives by helping mental health practitioners to identify and implement interventions that encourage them to seek treatment before they become more ill and need to be hospitalized.

Chapter 1 was an overview of the factors that might affect the underuse of mental health services by African Americans diagnosed with schizophrenia. The chapter also highlighted key factors related to historical events that have helped to create mistrust of the health care system and disparities in mental health services for African Americans. Chapter 2 is a review of previous literature and includes a discussion of the need for further research. The chapter also highlights key factors related to historical events that have helped to create mistrust of the health care system and disparities in mental health services for African Americans. Chapter 3 explains the methodology, and Chapter 4 presents the results. Included in Chapter 5 is a brief overview of the results, a discussion of the implications of the results for social change, and recommendations for further research.

# Chapter 2: Literature Review

The purpose of reviewing the literature was to establish a theoretical framework to investigate the problem being studied. The literature review includes key elements in the underuse of mental health services by members of the African American community diagnosed with schizophrenia, barriers to seeking mental health services, nonadherence to medication, and stigma. Presented in the chapter is a review of previous phenomenological research. The review of the literature exposed a gap regarding the reasons for the underuse of mental health services by members of the African American community diagnosed with schizophrenia. According to Aveyard (2010), a literature review is an evaluative report of previous studies related to the topic under investigation, and it is intended to clarify and summarize the literature under review and help to identify gaps in the available research.

## Purpose

The purpose of the study was to add to the current knowledge base information about the reasons for the underuse of mental health services by members of the African American community diagnosed with schizophrenia. Several obstacles that might hinder the use of mental health services include misdiagnoses, poor experiences with treatment or attempts to get treatment, and the lack of trust of mental health care providers. According to Lawson (2014), African Americans are more likely than European Americans to be diagnosed with schizophrenia. Lawson as well as Snowden (2012) emphasized that psychiatric bias and diagnostic ethics might be responsible for disparities in the delivery of mental health services to the African American community.

## Historical Trauma of African Americans

Lawson (2014) asserted that because many African Americans believe that racism is a core element of U.S. society, they expect that institutions perceived as being created and controlled by the so-called “White Establishment” will not treat them fairly. “The overdiagnosis of schizophrenia has led to inappropriate treatment, including excessive use of antipsychotics, excessive dosing, and under prescribing of mood stabilizer, and the result is substandard care, and poorer outcomes for Blacks” (Metzl, 2009, p. 2). According to Alexander (2012), Coates (2014), and Metzl (2009), African Americans’ psychic wounds are the result of 250 years of slavery, 90 years of Jim Crow, 60 years of separate but equal, 35 years of state-sanctioned redlining, 50 years of overdiagnosis of schizophrenia, and at least 30 years of incarceration. African Americans’ trauma has not yet been recognized by European American health care professionals.

Barnes (2008) addressed the predictors leading to the misdiagnosis of schizophrenia in African Americans. The example given was that of a European American female psychiatrist who had been a prescribing doctor for 20 years. During his intake interview, an African American patient appeared agitated, so the physician wanted to prescribe haloperidol for him. Fortunately, an African American staff member was present and was able to explain the reason for the patient’s agitation, namely, his discomfort with the color of her skin. African Americans continue to distrust the European American health care community. This explanation resulted in the patient receiving the appropriate treatment rather than being misdiagnosed with schizophrenia.

## African Americans' Distrust of the Medical Community

Crenner (2011) discussed the roadblocks in getting African Americans engaged in their treatment for mental health problems. Crenner suggested that one roadblock is distrust in the health care system. Misinformation, racism, and financial circumstances that create barriers can reduce the likelihood of African Americans seeking mental health services. Crenner asserted that the biggest obstacle is the stigma attached to having a mental illness. Crenner noted that in the African American community, it has been a tradition not to discuss mental illness. Crenner also mentioned that earlier research, particularly the Tuskegee experiment involving leaving the syphilis in African American men untreated, despite the existence of a readily available cure, might have led to African Americans' distrust of the medical system.

Metzl (2009) argued that African Americans are at greater risk than European Americans of being diagnosed with schizophrenia, an assertion that raises questions about the influence of racism and bias. Metzl contended that race has been part of the definition of mental illness since the 1850s, when European psychiatrists believed that African Americans who ran away from their slave owners were mentally ill. If African Americans protested against this social injustice, they were viewed as schizophrenic. Metzl explained, "European Americans could not understand why African Americans wanted to be free and treated equal. Race should be entirely unimportant to European psychiatrists when making a diagnosis" (p. ix).

The Tuskegee experiment increased the cultural mistrust of members of the African American community of institutional forms of health care services. The

Tuskegee experiment, which ran from 1932 to 1972 in Macon County, Alabama, involved 600 African American men, 399 of whom had syphilis. Initiated by the U.S. Public Health Services and continued by the Centers for Disease Control and Prevention, the experiment allowed the syphilis to go untreated so that doctors could observe its effects on the men's bodies. The Tuskegee Institute began the study to record the natural history of syphilis in hopes of justifying treatment programs for Blacks.

The study was conducted without the benefit of patients' informed consent. Researchers told the men they were being treated for "bad blood," a local term used to describe several ailments, including syphilis, anemia, and fatigue. In truth, the men did not receive the proper treatment needed to cure their illness. In exchange for taking part in the study, the men received free medical examinations, free meals, and burial insurance. Although originally projected to last 6 months, the study continued for 40 years. At least 40 spouses were diagnosed with the disease, and it also was passed on to 19 children at birth.

In 1947, penicillin became the standard treatment for syphilis, but the doctors who were involved in the Tuskegee experiment did not treat any of the participants with penicillin and chose, instead, to continue the experiment, raising the level of mistrust in the African American community of European American doctors. The participants were allowed to die deliberately from untreated syphilis, even though their deaths were supposedly attributed to tumors, paralysis, blindness, insanity, and heart disease. In several surveys, researchers have found that African Americans have expressed their fear of being used as guinea pigs in medical research. These fears might have influenced their decision to pursue medical treatment.

In another study conducted from 1946 to 1948, the Tuskegee experiment was repeated in Guatemala. Seven hundred men, woman, soldiers, and mental patients were intentionally infected with syphilis without their consent. The purpose of this study was to determine whether penicillin could prevent, not just cure, syphilis. Some of the individuals who had been infected never received treatment. The results of the study, which took place with the cooperation of Guatemalan government officials, were never published. The American public health researcher in charge of the project, Dr. John Cutler, went on to become a lead researcher in the Tuskegee experiments.

## African Americans and Schizophrenia

Snowden (2012) reported that African Americans are overdiagnosed with schizophrenia and are more likely than European Americans to not seek treatment or to receive substandard treatment. Chao, Mallinckrodt, and Wei (2012) concluded that mental health disparities are embedded in the socioeconomic factors of income and race. They also noted that racial discrimination against African Americans is pervasive and manifests on a regular basis in obvious ways, such as in substandard mental health services.

Snowden (2012) reported that eliminating mental health disparities could include improving the representation of minorities in the health care system and evaluating programs to increase interest among minorities in seeking mental health services. Snowden reported that these solutions would be an important first step. Lawson (2014) agreed that medical professionals might lack real awareness of racism and its distress. Moreover, Lawson asserted that cultural mistrust on the part of African Americans may manifest in symptoms that mimic paranoia. Lawson noted that 2.1% of African Americans with mental illness, compared to 1.4% of European Americans with mental illness, are diagnosed with schizophrenia.

Researchers have not determined why African Americans are more likely to be diagnosed with schizophrenia. One reason could be that African Americans simply might be more prone to developing schizophrenia. Another possibility might be that clinicians from majority groups are being unintentionally biased when making diagnoses. Yet another reason might be that African Americans are more likely to be poor and uninsured, making it difficult, if not impossible, to seek mental health treatment. According to Lawson (2014), poor Hispanic Americans also are more likely than poor European Americans to receive a diagnosis of schizophrenia. Lawson also recognized that even though negative stereotypes and rejecting attitudes have decreased, they continue to occur often enough to result in measurable adverse consequences for the mental health of African Americans.

Consequently, if the health care professionals treating African Americans have never experienced racism, it might never occur to them that racism could be painful. Sometimes, therapists might implement a universal approach when working with diverse populations. Lawson (2014) asserted that this type of approach is a form of racism that could interfere with development of the provider-patient bond.

According to Durbin, Rudoler, Durbin, Laporte, and Callaghan (2014), African Caribbean Americans and African Americans are at greater risk than European Americans of being hospitalized for schizophrenia. Durbin et al. admitted that less is known about the risk factors concerning other racial groups at this time. Their research focused on racial differences in the admission of schizophrenic patients to a California hospital between 1990 and 2008. The study sample included patients admitted for appendicitis-related problems and no indication of schizophrenia but were treated for schizophrenia anyway.

Durbin et al. (2014) used the logistic model to examine how patients' race, ethnicity, and SES, as well as the presence of primary care clinics, affected hospital admissions for schizophrenia. Compared to European Americans, African Caribbean Americans and African Americans had an increased risk of being diagnosed with psychiatric disorders and were more likely to be hospitalized for these disorders. Durbin et al. stated that there was evidence among Hispanic Americans and Asian American populations concerning psychotic illness associated with health services. The study continued for 5 years so that Durbin et al. could gather data that were appropriate and could contribute to the reliability and validity of the results.

Durbin et al. (2014) studied 319,957 participants between the ages of 14 and 90 years who had been admitted to hospital between 1999 and 2005. They used data from the U.S. Census (2000) to determine zip code characteristics, including the percentage of non-European American population per zip code. The data reflected racial ethnic neighborhood composition, the percentage of people per zip code in urban versus rural areas, and the mean per capita income for other racial ethnic groups. In addition, Durbin et al. used zip code data to determine whether the given populations lived in urban or rural areas.

Durbin et al. (2014) reported three key objectives of the study. The first objective was to determine whether a positive correlation existed between the risk of hospital admission of African Americans with schizophrenia and that of other racial ethnic groups. African American and Caribbean Black men showed the greatest risk of a diagnosis of schizophrenia as well as hospitalization. The second objective was to evaluate a possible correlation between first admission for different ethnic groups and the influence of zip codes for a diagnosis of schizophrenia. The third objective was to determine whether the likelihood of admission for schizophrenia was based on care of the patient being community based, defined as primary care clinics per 100,000 population.

Durbin et al. (2014) suggested several possible explanations for the higher rates of hospitalization for American Americans that they noted in their study. One explanation might have been the underlying differences in rates of schizophrenia. Durbin et al. cited several previous studies by Snowden suggesting that clinicians’ overdiagnosis of schizophrenia might have accounted for the higher risk of admission for schizophrenia among African Americans. This risk might have been the result of clinician bias in decision making related to the lack of cultural considerations when accessing specific criteria necessary for diagnosis, including misinterpreting cultural expressions of emotion. In particular, suspiciousness or paranoia might have reflected the experiences of

African American patients related to racism and oppression rather than to clinical pathology (Durbin et al., 2014).

## Language Barriers

F. M. Rodriguez (2011) identified limited English proficiency (LEP) as a risk factor that affects millions of people living in the United States. This factor can disproportionally affect ethnic minorities in negative ways. LEP often translates into communication barriers that can affect the quality of care because of the poor exchange of information, loss of cultural information, and misunderstanding of medical instructions. F. M. Rodriguez also suggested that medical professionals sometimes find it difficult to maintain communication as a high priority because of changing priorities in mental health care. Tarman (2015) reported that African Americans sometimes communicate with derailed references or loose associations that might be confusing to medical professionals. Language barriers can interfere with the patient-provider relationship and hinder the receipt of appropriate mental health services.

Language barriers also might account for the roadblocks that can happen when and if treatment is required. The underuse of services might be the result of an insufficient number of mental health professionals working in community health clinics providing services to African Americans. Gara et al. (2012) suggested that mental health providers receive training to learn about differences in and the needs of the cultures of the populations they serve.

## Stigma and Interventions

Mittal, Sullivan, Chekuri, Allee, and Corrigan (2012) conducted an empirical study concerning self-stigma, which the researchers defined as the harm that occurs when the prejudices embodied in public stigma are internalized. The researchers wanted to find ways to reduce the stigma associated with mental illness. They identified two areas of concern: The first involved interventions to alter stigmatizing beliefs and attitudes, and the second involved interventions to improve coping skills, empowerment, and self-esteem. Mittal et al. used data from previous studies describing interventions used by people who had experienced the stigma associated with having a mental illness such as schizophrenia.

Mittal et al. (2012) tested the interventions and analyzed the quantitative data. According to their findings, the second approach was more successful in decreasing the underuse of mental health services by members of the African American community. According to Mittal et al., psychoeducation had been used more frequently than any other intervention. Consequently, they found that several studies lacked theoretical frameworks for their interventions and that six different scales had been used to measure stigma. Self-stigma definitions, measurements, and conceptual frameworks varied significantly across the studies. In several studies, the theoretical frameworks were found to be unreliable. Mittal et al. concluded that further research was needed to find solutions to reduce and define the stigma associated with mental illness. Earlier researchers had identified the need to comprehend the relationship between stigma and the help-seeking behaviors of members of the African American community.

Ward, Wiltshire, Detry, and Brown (2013) sought to understand why African Americans were not open to receiving treatment for mental health issues. The researchers concluded that the African American participants in their study continued to view stigma as a deterrent to seeking medical help. Consequently, stigma had an effect on their psychological openness and help-seeking skills that also influenced their coping skills. Ward et al. found that although the participants were not open to admitting that they had a mental illness, they were somewhat open to seeking mental health services.

Y. E. Rodriguez (2014) studied the effectiveness of psychosocial interventions. In the past, interventions such as cognitive behavioral social skills training (CBSST) had demonstrated a positive effect on the treatment of people with serious mental illness. According to Y. E. Rodriguez, little was known about whether this type of intervention would be effective with members of minority communities. Previous researchers had reported that racial, ethnic, and cultural factors might have affected symptom expression, diagnosis, treatment outcomes, and health care services.

Y. E. Rodriguez (2014) wanted to find out whether minorities, compared to non-Latina European Americans, diagnosed with schizophrenia would show any improvement after receiving CBSST treatment. The participants were recruited from the San Diego University of California, San Diego Outpatient Psychiatric Services; San Diego County assisted living facilities; and private psychiatrists. The sample comprised 85 European Americans, 21 African Americans, 27 Latino Americans, and 16 participants who self-identified as other racial minority and ethnic minorities. Y. E. Rodriguez assessed several areas that included neurocognition, social cognition, negative symptomatology, psychosocial functioning, and CBSST mastery and retention.

Y. E. Rodriguez (2014) commented:

> Psychosocial rehabilitation for racial/ethnic minorities revealed no social cognitive differences between racial/ethnic minorities and White participants. However, Latinos in CBSST did endorse lower levels of defeatist beliefs compared to Blacks. We found no other differences in social cognition (e.g., social anhedonia, theory of mind, social competence) between White, Latino, and Black participants. Latinos also demonstrated higher quality of life during CBSST when compared to White participants, consistent with previous research which showed better outcomes in non-U.S. Overall, racial/ethnic minorities in our sample benefitted from our manualized treatment interventions and demonstrated learning and skill mastery while in treatment. (p. 365)

## Use of Mental Health Services

Results of Alvidrez, Snowden, and Patel’s (2010) study showed that as African Americans’ untreated schizophrenia became more severe, emergency interventions became necessary. Alvidrez et al. conducted their study to incorporate the patients’ voice into written psychoeducational material for African American adults about stigma and other attitudinal barriers to mental health services. Fear of hospitalization and fear of coercive treatment were identified as common concerns that prevented African Americans from seeking mental health services.

Conducting qualitative interviews with African Americans with schizophrenia produced vital material of their life experiences with stigma and practical strategies to cope with the stigma that could be included in psychoeducational interventions (Alvidrez et al., 2010). Psychoeducational interventions have been used successfully for the pretreatment orientation of patients to enhance their knowledge about mental health treatment. Researchers have suggested that the interventions can be customized to fit any ethnic group. Williams (2013) reported that this type of treatment has generally focused on a lack of information or awareness about mental illness, not specifically on the stigma associated with schizophrenia. It also has not focused on other treatment barriers.

Horvitz-Lennon et al. (2015) examined two factors to determine whether the quality of care for patients with schizophrenia varied by race and ethnicity over time, and whether these patterns were different across states. The researchers focused on Medicaid claims data from Florida, North Carolina, New York, and California from 2002 to 2008. Participants were African Americans, European Americans, and Latino Americans who received Medicaid benefits and had been diagnosed with schizophrenia.

According to the *DSM-5* (APA, 2013), schizophrenia is a serious mental illness associated with high levels of disabilities in emotions, cognitive ability, and behaviors that include social isolation, self-harm, and repetitive movements; mood changes, including anxiety; inappropriate emotional responses, along with psychological symptoms such as hallucinations, paranoia, delusions, and incoherent speech; and false beliefs of superiority. Medicaid is one of the largest recipients of state spending, accounting for approximately one quarter of total spending directed toward people with mental health issues (National Association of State Budget Officers, 2013).

Horvitz-Lennon et al.’s (2015) study included 164,014 participants. Results showed that the quality of medical care for European Americans in all four states was higher that the care of African Americans. The quality of health care also was lower for Latino Americans in three states, with the exception being Florida. In counties in each state, the quality of and disparities in health care varied. Disparities were more significant for African Americans. Schizophrenia is a serious mental illness associated with high levels of incapacities, and Medicaid is the primary source of health care coverage for most African Americans diagnosed with schizophrenia.

In general, Horvitz-Lennon et al.’s (2015) results were consistent with previous findings about disparities in health care services for African Americans. According to Horvitz-Lennon et al., between 2002 and 2008, African American Medicaid patients with schizophrenia in California, Florida, New York, and North Carolina received a quality of care that was below average when compared to the care received by other racial groups. Moreover, evidence suggested that zip codes, including state of residence and other local factors, played an important role in patterns of care.

## Treatment and Side Effects

Fisher, Lowery, Hardy, Schlosser, and Vinogadov (2013) highlighted several important shifts that have occurred in the treatment of schizophrenia, including a focus on early detection and the development of preventive interventions for individuals with schizophrenia. Cabassa, Ezell, and Fernández (2010) outlined various types of treatment used to reduce the symptoms of schizophrenia, including the use of psychotropic medications, psychosocial interventions, assertive community treatment, case management services, electroconvulsive therapy, cognitive behavioral therapy, vocational rehabilitation, and lifestyle change.

Researchers have suggested that the current treatment of schizophrenia can help to reduce some of the symptoms associated with it. Lane (2015), for example, argued that even with treatment, some patients might continue to experience residual symptoms of their illness without exhibiting any distinguishing positive symptoms such as a reduction in hallucinations, delusions, and racing thoughts. In addition, patients might continue to experience negative symptoms of schizophrenia, including limited verbal expression, odd behavior, disorganized speech, and the belief that they have magical power.

Gilleen, David, and Greenwood (2010) reported that the treatment of schizophrenia requires a lifelong regimen of drugs, psychosocial support, and support therapies. According to Gillen et al., medication and psychosocial support are believed to enhance the lives of people who live with schizophrenia. Medications can reduce or control symptoms such as delusions and hallucinations that are associated with psychosis. Snowden (2012) asserted that the advantages of psychotherapy interventions are that they can help people to change the way they think and behave better, even if the situation remains the same.

Large and Ryan (2014) documented that taking psychotropic drugs can double the risk of suicide and that long-term use can result in a lifetime of physical and mental damage. According to the National Institute of Mental Health (NAMH, 2013), the Food and Drug Administration noted in 2004 that less than 1% to 10% of adverse drug effects are actually reported by patients and doctors. In addition, Gorman, Kapur, Kolluri, and Kane (2011) reported that antipsychotic medications can produce changes in the brain that can produce several adverse side effects such as tardive dyskinesia, Parkinsonian syndrome, and neuroleptic malignant syndrome (NMS). There also appears to be a crucial point at which to switch medications.

The APA (2013) described NMS as a serious side effect associated with antipsychotic and psychotropic medications that can result in death. Treatment for NMS normally includes hospital care and discontinuation of antipsychotic drugs. Antipsychotic medications help to reduce the symptoms associated with schizophrenia, but many of them have irreversible side effects such as muscle inflexibility, fever, autonomic unsteadiness, and cognitive changes such as hallucinations

Mahmood, Levy, Vasan, and Wang (2013) asserted that in the majority of cases, NMS might develop among patients within the first couple of weeks of taking the drugs. However, side effects from taking the medications might develop in patients at any time while they are taking the drugs. Buchanan et al. (2009) further suggested that symptoms might include twitching or jerking movements in the face, tongue, or other parts of the body that cannot be controlled, all of which are symptoms of tardive dyskenisia.

Tardive dyskinesia is associated with psychotropic medications. The risk of developing tardive dyskinesia and the chance that it will become permanent are thought to be associated with the duration and dosage of medications. Buchanan et al. (2009) noted that even though there is no known cure for schizophrenia, cogentin and other medications are prescribed to reduce unwanted side effects. Side effects might cease partially or even entirely if medication is discontinued before it can do permanent damage.

Holthausen (2007) reported that some antipsychotics might pose a risk for a complex disorder known as metabolic syndrome, whose side effects include, but are not limited to, weight gain, diabetes, hyperlipidemia, myocarditis, hypertension, and cataracts. Mahmood et al. (2013) noted that other medications can be prescribed to help reduce some, but not all, of these side effects. It is obvious that psychotropic medications vary in their level of inducing metabolic syndrome problems such as obesity, diabetes, and hypertension.

## Causes of Schizophrenia

Schizophrenia affects 1% of the U.S. population, and a combination of genetics and environmental factors might be contributing to the development of the disorder, suggesting potential genetic roots (NIMH, 2013). To establish the possibility that schizophrenia might run in families, a study was conducted by an international research group that analyzed and incorporated data from genome-wide association studies of five major disorders: schizophrenia, depression, bipolar, autism, and attention deficit hyperactivity disorder. The study, which was conducted by the Cross-Disorder Group of the Psychiatric Genomics Consortium (2013), involved scanning thousands of genetic markers to screen for evidence of illness associated with genetic variations among 33,000 patients. The researchers were looking for tiny variations that appeared more frequently in individuals who had been diagnosed with particular disorders. All of the patients had been diagnosed with at least one of the five major disorders. A comparison group of 28,000 individuals did not exhibit any major psychiatric diagnoses. The results revealed significant variations associated with all five major disorders.

Distinctions were noted in the group that had been diagnosed with at least one of the five major disorders in certain regions of Chromosomes 3 and 10. Chromosome 3 had the stronger link between bipolar disorder and schizophrenia. Variations also were noted in two genes responsible for regulating the flow of calcium into neurons in the brain. Previous research had linked the two genes, CACN1C and CACNB, to bipolar disorder and schizophrenia. Although the results indicated that both genes and certain regions of chromosomes showed variations, the researchers in the Cross-Disorder Group of the Psychiatric Genomics Consortium (2013) remained cautious about the findings, unsure that schizophrenia can be predicted through heredity. However, both genes affect brain circuitry involved in cognition, emotions, attention, and memory; these insufficiencies have been observed in people diagnosed with schizophrenia.

Park et al. (2015) found that neuronal abnormalities, including altered glutamatergic function, deficits in dopaminergic function, and impaired neurodevelopment, can contribute to the cause and development of schizophrenia. According to Park et al., evidence has suggested that abnormal neurodevelopment during the perinatal and early adolescent stages might result in a dysfunction of the neural network that could develop into schizophrenia later in life. They stated, “In addition, dysregulation of the immune system, along with genetic and environmental factors, is known to contribute to abnormal neurodevelopment processes, which leads to the pathogenesis of schizophrenia" (p. 2).

Park et al. (2015) also identified a close relationship between mental illness and the innate immune system, asserting that a dysregulated immune system causes psychiatric disorders. Results of their study confirmed that the toll-like receptor-2 (TLR-2), a member of the family of pattern-recognition receptors, is involved in the pathogenesis of schizophrenia-like symptoms. Psychotic symptoms such as hyperlocomotion, which is usually the result of excessive stimulation of the nervous system's anxiolytic-like behaviors, weakened inhibition deficits, social withdrawal, and cognitive impairments, were observed in TLR-2 (Park et al., 2015). "Toll-like receptors are known to play an important role in neurodevelopment, adult neurogenesis, neuroplasticity, learning, and memory in the absence of any underlying immune activation" (Park et al., 2015, p 5). Park et al. concluded that deletion of the TLR-2 gene in mice caused the typical behavioral, histological, and pathophysiological characteristics observed in patients with schizophrenia.

Weidginer et al. (2013) reported that examination of the immune system revealed alterations in the TLR-4 pathway of patients with schizophrenia versus patients who showed no signs of the disease. Twenty-five patients with schizophrenia and 16 participants who did not have schizophrenia comprised the sample. To analyze the appearance of central proteins of the TLR-4 pathway, blood samples were taken once from the control group and twice from the patient group.

Blood samples were taken from the patient group prior to their starting antipsychotic medications. Peripheral blood mononuclear cells were separated, and 84 genes were analyzed in the TLR-4 pathway. Results revealed an increased number of TLR-4 but decreased responsiveness after stimulation, with lipopolysaccharides, in the sense of an endotoxins tolerance, in the participants with schizophrenia that was seen as the result of a chronic activation of the immune system that had been observed in patients diagnosed with schizophrenia (Weidginer et al., 2013).

Garcia-Bueno et al. (2016) identified specific reasons to study TLR-4s in individuals with schizophrenia. Previous studies had indicated that TLR-4 might play an important role in neurodevelopment and plasticity. TLR-4 could participate conclusively in the priming alterations of the immune system after infection and stress. In addition, an altered microbiome, signs of intestinal inflammation, increased intestinal barrier permeability, and bacterial translocation caused by elevated TLR-4 levels are present in patients with schizophrenia that might be caused by elevated TLR-4 levels.

To test their hypothesis, Garcia-Bueno et al. (2016) recruited 214 patients from Barcelona, Spain, who had been diagnosed with schizophrenia to join the study. Blood was taken throughout the study to test TLR-4 levels. The researchers evaluated the TLR-4 pathway at different stages, that is, from genes to protein level, to strengthen evidence of its role in the pathophysiology of schizophrenia and other physical problems. Results showed that if TLR-4 is altered, it can affect the immune responses of patients with chronic schizophrenia. They noted, “The predictive capacity of our genetic model for schizophrenia, which includes SNPs in 5 TLR4 pathway genes, would need to be validated in independent populations" (p. e55).

Ergün, Urhan, and Ayer (2017) sought to determine the relationship between gluten in the diet and the onset of schizophrenia. Dohan (1966) theorized that removing gluten from the diet could result in a significant reduction of schizophrenic symptoms. Ergün et al. reported that the prevalence of celiac disease among people diagnosed with schizophrenia is nearly 2 times higher than in the general population. Other disorders associated with celiac disease are depression, anxiety, autism, and attention deficit hyperactivity disorder. Celiac disease affects 1% of the European American population and a lower percentage of African Americans, Asians, and South Americans.

Gluten is a protein in wheat products that acts as glue to hold food together. Problems with gluten are commonly associated with celiac disease, an autoimmune disorder in which the immune system responds abnormally to gluten, which then damages the small bowel. This damage interferes with the absorption of nutrients and can lead to gastrointestinal and other disorders. Ergün et al. (2017) suggested that the effects of gluten and celiac disease can precipitate the onset of schizophrenia.

Results of previous studies such as that by Dohan, Harper, Clark, Rodriguez, and Zigas (1984) suggested that the symptoms associated with schizophrenia are minimized when gluten is omitted from patients' diets. Dohan et al. hypothesized that gluten might be an environmental trigger for schizophrenia in genetically susceptible individuals and that patients with schizophrenia share one or more genes with individuals who have celiac disease. Forty-seven participants in their study were men with schizophrenia from a locked in-patient ward randomly assigned to a cereal-free diet and 55 who were assigned a high-cereal diet. Dohan et al. reported that 62% of the patients on the cereal-free diet were released to a nonlocked ward prior to the average 7-day stay versus only 36% of those on the high-cereal diet.

Dohan et al.'s (1984) study was repeated by Jackson, Eaton, Cascella, Fasano, and Kelly in 2012. Patients with schizophrenia who had relapsed were randomly assigned to a gluten-free diet versus a diet containing gluten. Thirty-seven percent of the participants who were on a gluten-free diet were discharged to the open ward 90 days after admission versus only 16.1% of those on a diet that contained gluten. Researchers have suspected that the benefits of a gluten-free diet might be obtained from circulating, food-derived peptides exerting an influence on physiological processes in the brain.

Wei and Hemmings (2005) reported that schizophrenia and celiac disease involve a genetic component and that children with a history of celiac disease are at greater risk of developing schizophrenia. Wei and Hemmings suggested that the gene-environment interaction might be the result of a change in stomach permeability, meaning that the stomach might lose its capacity to block exogenous, psychosis-causing substances that might enter the body, causing schizophrenia and other mental conditions to develop. To support their theory, Wei and Hemmings conducted a conditional test to look at the combined effect of the CLDN5 gene involved in forming permeability barriers and the DQB1 gene, which has been found to be associated with celiac disease. Results indicated that the two genes probably work together to increase susceptibility to schizophrenia.

Singh and Kay (1976) reported that individuals with schizophrenia who were placed on a grain diet and who were receiving optimal treatment with neuroleptic medications had a reversal of their schizophrenic symptoms. Flare-ups of the disease process were not the result of variations in neuroleptic doses. After gluten was removed from their diets, their symptoms improved. According to Singh and Kay, this improvement in symptoms appeared to be the direct result of the elimination of wheat gluten.

Eaton et al. (2004) cited Dohan to demonstrate the association between celiac disease and schizophrenia and that patients with celiac disease and schizophrenia might respond dramatically to a gluten-free diet. Dohan (as cited in Eaton et al., 2004) theorized that the genotype for idiopathic schizophrenia overlapped somewhat with that of celiac disease and concluded that based on extensive epidemiological studies correlating grain consumption with the incidence of schizophrenia, gluten is a major factor in the onset of schizophrenia. Eaton et al. suggested further investigation into the problem.

Exorphins, opioid peptides formed during the digestion of food protein, can be absorbed into the bloodstream from the stomach and might be able to pass through the blood-brain barrier and affect the central nervous system. Presence of these exorphins in patients with schizophrenia was reported by Jackson et al. (2012), who found increased levels of small peptides in the urine of patients with schizophrenia, some of which were neuroactive and displayed opioid-like effects. These peptides can affect behavior, induce changes in electroencephalograms, and cause alterations in neurotransmitter levels. Specific exorphins that might implicate a link between symptoms of schizophrenia and celiac disease include members of the casomorphin family, including b-casomorphin-7, a peptide produced from the digestion of casein in milk.

This peptide can cross the blood-brain barrier and activate antgliadin antibodies that appear to cross-react with neurological self-structures, which might explain how they contribute to schizophrenia. Jackson et al. (2012) compared the blood work of 950 individuals with schizophrenia to that of 1,000 healthy controls. They discovered that the likelihood of having antgliadin antibodies was 2.13 times higher in individuals with schizophrenia, meaning that they were more likely to experience an adverse immune response to wheat proteins.

## Lifespan of Schizophrenic Patients

Crump, Winkleby, Sundquist, and Sundquist (2013) conducted a study at Lund University in Sweden. Results indicated that people with schizophrenia had a shorter life expectancy than the general population. The research was conducted from 2003 to 2009 on individuals 17 years of age and older who had been diagnosed with a mental disorder. The study encompassed all citizens living in Sweden between January 1, 2003, and December 31, 2008, which was estimated to be 7,253,516. It was determined that 377,339 people had been diagnosed with a mental illness and that suicide had been the primary cause of death. Premature death was estimated to number 227,770 for people with a mental illness. The information was obtained using the Swedish Death Registry, which documents 99.9 % of deaths in Sweden. Results also revealed that individuals diagnosed with schizophrenia had doctor visits twice as often as other patients (Crump et al., 2013). Results suggested that medical professionals were failing to detect or diagnose heart disease and cancer in people diagnosed with schizophrenia.

Nordentoft et al. (2013) found that the mortality rate was much higher for individuals diagnosed with schizophrenia than for people in the general population. According to their results, people diagnosed with schizophrenia had a 12- to 15-year reduction in life expectancy. Listed in the research were four main reasons for the difference. Nordentoft, et al. found that physical illness in people with schizophrenia usually was not diagnosed and that if it were, it was treated insufficiently. In addition, people diagnosed with schizophrenia usually had substandard lifestyles that included unhealthy eating habits, excessive alcohol use, drug use, smoking, lack of exercise, and the use of psychotropic drugs that caused adverse side effects. Suicide and accidents also were listed as reasons for the high mortality rate of people diagnosed with schizophrenia.

Bushe, Taylor, and Haukka (2010) reported that at the time of their study, people diagnosed with schizophrenia had a mortality rate of 40% resulting from suicide and unnatural deaths. Unnatural deaths were determined to be caused by unhealthy lifestyle choices that included smoking and obesity. Several other risk factors were identified as the same risks in the general population. Similar factors for people with schizophrenia were loss of family members, depression, drug misuse, and previous suicide attempts. Factors related to schizophrenia included fear of mental disintegration, anxiety, and poor or nonadherence to treatment. Burdick, Ketter, Goldberg, and Calabrese (2015) reported that cardiovascular disease accounted for one third of natural deaths and cancer accounted for nearly one in six deaths. Premature deaths also were related to diabetes, chronic obstructive pulmonary disease, pneumonia, and the flu.

## Literature Search Strategy

I used Walden University Library's database to retrieve older articles that could justify the research methods, along with journal articles, books, and magazines. Search results were limited to articles published between 2009 and 2016. I reviewed approximately 200 articles and identified 80 as pertinent to the underuse of mental health services by members of the African American community diagnosed with schizophrenia, disparities in mental health services, stigma, barriers to mental health services, and cultural bias in health care. Limited resources from 1984 to 2008 also were used.

## Literature Review Related to Key Variables

Anderson (2011) used a phenomenological approach to explore the lived experiences of five African American men between the ages of 21 and 57 years who had been diagnosed with schizophrenia. Anderson was interested in determining whether the patients were aware of their illness and the ways that they experienced reality. Anderson's study was guided by one RQ: For African American males diagnosed with schizophrenia, what is the experience of living with this disorder? Analysis of the interview responses identified four overarching themes: Participants knew that they were mentally ill; they made a special effort to test reality; they asserted their autonomy; and they experienced reality differently, something that they saw as a gift.

Jarosinski (2008) used a phenomenological approach to examine the experiences of participants in a study regarding what it was to live with hallucinations. The study was guided by one RQ: What is the meaning of hallucinations, and how do hallucinations connect to one's sense of self? The participants had been diagnosed previously with schizophrenia and schizoaffective disorder. Jarosinski was able to identify four themes: (a) Are they who they are? (b) a not-so-certain life, (c) finding strength in broken places, and (d) I am still me. The participants described their thoughts about being made to feel different and separate from other people. Jarosinski concluded that hallucinations were a factor contributing to the participants' feelings of powerlessness and sense of being resigned to their fate.

Tarman (2015) used a phenomenological approach to explore the lived experiences of nine rural African Americans' underuse of or lack of access to mental health services. Tarman concluded that instead of seeking help at mental health facilities, African Americans prefer to seek help from church leadership. The explanations given were that the economic disparities of many African Americans restrict their ability to pay for mental health services and that they fear being stigmatized by medical professionals. For example, unethical medical and research practices such as the Tuskegee experiment toward African Americans have led to resistance to seek or participate in mental health services. The central RQ focused on their perceptions of professional mental health services and counseling approaches.

To explain this phenomenon further, Tarman (2015) recruited six African American pastors to join the study. Their average age was 30 years. Four themes emerged from the results: stigma associated with having a mental illness, acceptance by others, coping and support, and mistrust of their provider. Tarman concluded that even though many studies have been conducted on the underuse of mental health services by members of the African American community, a gap remains in addressing the limited use of mental health services by African Americans diagnosed with schizophrenia. In 2013, Fleurantin suggested that the gap in the literature concerning the underuse of mental health services by members the African American community needed to be addressed.

## Conclusion of Studies

I followed a phenomenological, qualitative approach to explore the underuse of mental health services by members of the African American community. Rubin and Rubin (2012) discovered that qualitative research is invaluable when researchers are attempting not only to gain a full and deep understanding of the experiences of the participants but also to reconstruct events in which the researchers did not participate. Creswell (2007) explained that a phenomenological approach that can be used to understand the lived experiences of the participants from their points of view is through face-to-face interactions.

## Summary

Britt (2009) commented that qualitative research is appropriate when study samples are small and researchers want to obtain a more in-depth understanding than is typically achieved from survey data alone. Creswell (2007) asserted that the basic purpose of phenomenology is to reduce the participants’ experiences of the phenomenon being investigated to a description of the universal essence of the experience for all individuals. Creswell (2012) explained that phenomenology begins with a question. I used a phenomenological, qualitative approach to identify the barriers influencing the underuse of mental health services by members of the African American community diagnosed with schizophrenia.

Van Manen (1997) argued that a hermeneutic phenomenological approach is well suited for studying people’s lived experiences. A phenomenological approach allows study participants to make meaning of their lived experiences of certain concepts or phenomena (Creswell, 2007). African Americans who have been diagnosed with schizophrenia but continue to underuse mental health services are the only people who can speak about what it is like to live with mental illness.

# Chapter 3: Research Method

Creswell and Clark (2007) suggested that using a phenomenological, qualitative approach gives researchers a flexible way to understand the lived experiences of human behavior and to give study participants the opportunity to provide in-depth accounts of their experiences of the phenomena being investigated. Biggerstaff (2009) reported that using this approach gives researchers the opportunity to develop an idiographic understanding of the participants’ lifestyles and environments within their social realities.

Rubin and Rubin (2012) explained that using a phenomenological approach gives researchers the opportunity to obtain in-depth details from the participants about the phenomena under study. In the case of the current study, I sought to obtain details explaining how individuals living with schizophrenia made sense of their personal and social environments and their feelings about being diagnosed with schizophrenia. A phenomenological design was appropriate for the study because of its emphasis on describing, understanding, and explaining a complex phenomenon.

## Research Design and Approach

I used a phenomenological design to help to close the gap in the literature concerning the reasons African Americans diagnosed with schizophrenia underuse mental health services. I chose a phenomenological design because of its emphasis on describing, understanding, and exploring certain behaviors. The study was guided by one RQ: What barriers influence the underuse of mental health services by African Americans with schizophrenia?

I developed five interview items to address the RQ:

1. Tell me about a typical day.
2. Do you perceive yourself as being different from others?
3. How would you describe your treatment for schizophrenia?
4. How many mental health appointments have you missed, and why?
5. Have you had any negative experiences in treatment or trying to seek treatment?

Use of a phenomenological research design was appropriate to meet the purpose of the study. Conducting in-depth interviews allowed me to explore the lived experiences of a sample of African Americans diagnosed with schizophrenia and the reasons for their underuse of mental health services. According to Creswell (2012), a phenomenological design provides a platform to give voice to individuals who are affected directly by the phenomenon to describe their lived experiences. I chose a phenomenological approach to identify patterns and themes associated with the African American participants' lived experiences. Through confidential and semistructured interviews with a small number of participants, I sought to better understand this phenomenon in an effort to close the gap in the literature.

## Role of the Researcher

According to Creswell (2007), qualitative researchers must organize and prepare the data for analysis, which involves transcribing the interview responses and sorting the information, which also might include any field notes generated. Then the researchers must read all of the data to gain a sense of their content and reflect on the overall meaning. The next step calls for researchers to begin detailed analyses of their data using a coding process to generate descriptions of the settings or people, as well as themes or categories for analysis. Then they must interpret or make meaning of the data. Jacob (2015) reported that it is imperative that researchers recognize any personal values, assumptions, or biases before conducting their studies and refrain from making personal judgments about the participants.

Creswell (2007) suggested that using a phenomenological approach allows qualitative researchers to identify the essence of human experiences concerning the phenomena under investigation and as described by the participants. Denzin and Lincoln (2005) asserted, “Qualitative research involves an interpretative, naturalist approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meaning people bring to them” (p. 3). I designed the study to bridge the gap in the literature regarding the underuse of mental health services by some members of the African American community who had been diagnosed with schizophrenia.

## Recruitment

After receiving approval from Walden University’s Institutional Review Board (IRB) to conduct the study (IRB approval #06-15-18-0044911), I recruited the participants. The sample comprised three African American men and three African American women between the ages of 29 and 55 years who had been diagnosed with schizophrenia, had been hospitalized several times since the diagnosis, and were residing in an independent residential community faculty at the time of the study. This complex houses only people with mental illness. I posted flyers on the residents' information board that explained the study in detail and the need for participants of African American descent who were diagnosed with schizophrenia. The flyer also included my contact information. Interested individuals had to be able to speak and read English, and they had to be able to consent voluntarily to join the study.

After recruiting the six participants, I met with them individually to explain the purpose of the study and the importance of signing the consent form. The participants did not sign the consent form during the first meeting; instead, I gave them time to consider their decision to join or decline to join the study. I also gave the participants a letter explaining the potential impact of the study might on research to identify the factors contributing to the underuse of mental health services by African Americans diagnosed with schizophrenia.

According to Creswell (2003), conducting audiotaped, semistructured interviews ensures the accuracy of the transcriptions. I conducted the interviews in the activity area. The length of each interview was contingent upon the detail in their responses. The interviews were considered complete when the participants conveyed that they had nothing else to add to their responses or when they decided to end their respective interview sessions.

## Inclusion and Exclusion Criteria

The study was limited to African Americans between the ages of 29 and 55 years who had been diagnosed with schizophrenia. Snowden (2012) and Metzl (2009) reported that African Americans, especially men, have been overdiagnosed with schizophrenia.

Fleurantin (2013) as well as Alvidrez and Snowden (2009) also suggested that African Americans underuse mental health services and do not adhere to medication regimens and other interventions. For these reasons, the study was limited to African American participants only.

## Consent Form

The participants had to sign the consent form before I could collect any data from them. The consent form outlined the purpose of the study and explained why they were invited to join the study. The form included the name of the university, my name, and my contact information. In addition, the consent form held an explanation that their participation in the study was voluntary and that they had the right to refuse to answer any questions, stop the interview at any time for any reason, and withdraw from the study at any time without repercussions. The consent form also included an estimate of the time needed to complete each interview.

I encouraged the participants to ask any questions before deciding whether to participate or decline to be in the study, and to read the entire consent form before signing it. The informed consent advised the participants that there was no compensation for being in the study and that I would keep all identifying information private and confidential. I also informed potential participants that I would record their responses to the interview items once I had their consent to do so. In the event that someone refused to be recorded, another potential participant was selected as a replacement. The form also notified the participants that I would destroy all of their recorded responses once the study had been completed, approved, and published.

## Data Collection

According to Creswell (2007), data can be collected during semistructured interviews. I designed the interview items to identify reasons for the underuse of mental health services by members of the African American community who had been diagnosed with schizophrenia. I prepared a prompt sheet with the five interview items in advance of conducting the actual interviews. Biggerstaff (2009) suggested that researchers prepare their interview questions and statements beforehand so that they can take the lead during the interview process. Biggerstaff also noted that the use of a recorder ensures that the participants’ statements are transcribed accurately.

Creswell (2003) mentioned that taking personal notes during the interviews could help researchers to capture participants’ frequently used phrases as well as their emotions. Researchers can then use the notes to document the participants’ body language and other any observable behaviors. Creswell (2012) also suggested that researchers read these notes and listen to the participants’ recorded responses several times to ensure the accuracy of the data collected. I collected data from the open-ended interviews, observations, and documents that might have included any field notes.

## Data Analysis

According to Creswell (2012), researchers must organize and prepare their interview data for analysis. The process involves transcribing the interview responses and sorting through the information, including field notes. Creswell recommended that researchers read the collected data to gain a sense of their content and reflect on their overall meaning. It is only at this time that researchers can begin to conduct detailed analyses using coding to generate descriptions of the settings or people and identify emergent themes or categories. Creswell also mentioned that narrative passages will help to convey the findings based on the interpretation of the data.

Pezalla, Pettigrew, and Miller-Day (2012) stated that researchers themselves are the main data collection instrument in qualitative research, particularly phenomenological research. They are involved in collecting the data by asking relevant questions during the interviews. I had a similar vital role in this study. I developed the skills needed to solicit rich and detailed information from the participants by reading about the research strategies of Creswell, Van Manen, and others. I prepared the interview guide prior to conducting the interviews to highlight the important items that I wanted to ask during the interviews.

I recorded and then transcribed the interview responses to confirm their accuracy and completeness. I collected and analyzed two forms of qualitative data, namely, the transcriptions of the interview responses and my field notes of any perceptions that stood out during the interviews. I used Qiqqa, a qualitative software program, to manage, code, and interpret the data; identify themes; and group and present the data.

## Data Management

I stored the interview data in a locked file cabinet. I will retain the data for 5 years before destroying them, as mandated by Walden University's IRB. Paper records relevant to the study will be shredded, and all electronic data stored on my computer hard drive will be erased using commercial software. Data stored on a USB will be physically destroyed. Once I reviewed the data, I prepared them for analysis. No participants were identified by name, and all information will remain confidential and will be stored on a password-protected USB flash drive.

## Issues of Trustworthiness

Creswell (2007) suggested that study participants who have been interviewed read their individual transcriptions to ensure their accuracy. Creswell noted that researchers who conduct interviews must be aware of any biases beforehand because personal biases can taint the findings of their studies. To support the reliability of the current study, I set aside personal biases and analyzed the data to capture the true experiences of the participants. Before conducting the interviews, I reviewed the informed consent with the participants and gave them copies for their own records.

## Ethical Procedures

Ethical considerations ensure that all study participants are protected from harm for the duration of the research. As mentioned earlier, my participants were exposed to minimum risk, and they had the right to withdraw from the study at any time without penalty. Creswell (2007) emphasized the importance of adhering to ethical principles. For example, potential research participants must know the purposes of studies before agreeing to be in them so that they understand the nature of the research and any impact that it might have on them. I informed the participants of all aspects of my study so that they knew what to expect during the interviews.

During the study, I did not suppress or falsify any information to support the findings. I kept all of the collected data confidential and stored them on a password-protected USB. I will destroy all information once the study has been completed, approved, and published. I did not recruit any participants or collect any data until I had received permission from Walden University's IRB to conduct the study.

## Summary

The purpose of following a phenomenological, qualitative approach is to understand the lived experiences of the phenomenon under investigation. In 1997, Van Manen reported that "phenomenology is a project of clear-headed reflection on the lived experience of human existence, it must be thoughtful and free from hypothetical, detrimental, and suppositional intoxications" (p. 13). I designed the study to add to the literature relevant to the underuse of mental health services by members of the African American community diagnosed with schizophrenia. Fleurantin (2013) suggested that further research is needed to bridge the gap in knowledge concerning the underuse of mental health services by African Americans diagnosed with schizophrenia.

# Chapter 4: Results

In this chapter, I provide demographic information about the six participants and summarize the results of the analysis of the data collected from the participants during the interviews and the notes that I took during the interviews. The purpose of the study was to explore the lived experiences of African Americans diagnosed with schizophrenia and their underuse of mental health services. I used a phenomenological research design to understand and explore the participants' lived experiences of the phenomenon. Through interpretive phenomenology, the research objective was to enrich clinicians' understanding of the ways that African Americans diagnosed with schizophrenia live their lives. According to Van Manen (1997), "The purpose of phenomenological reflection is to gasp the essential meaning of something" (p. 77).

## Participant Recruitment

In April 2019, I posted flyers on the community board at the residential facility to recruit participants for this study. This recruitment effort resulted in six residents, three African American men and three African American women, agreeing to join the study. The recruited participants met the criteria for inclusion in the study.

## Sample Demographics

All participants self-identified as African Americans. Their ages ranged from 29 to 55 years. Regarding educational level, three participants had earned a high school diploma, one had dropped out in Grade 8, and two had dropped out before completing high school. Concerning marital status, two participants had been married but had then divorced. Four participants had never married. Five participants had given birth to children (see Table 1).

Table 1

*Demographics of Participants*

| Age range | 29-55 yr. |
|---|---|
| Marital status | Divorced (*n* = 2) |
| | Single/Never married (*n* = 4) |
| Education | High school diploma (*n* = 3) |
| | Dropped out of high school (*n* = 2) |
| | Dropped out of Grade 8 (*n* = 1) |
| Employment | 3 were employed |
| Age when diagnosed | 16-25 yr. |
| Current treatment | Psychiatrist medication management |
| | Case management (*n* = 6) |
| | Alcoholics Anonymous (*n* = 4) |
| | Narcotics Anonymous (*n* = 6) |
| | Peer support group (*n* = 6) |
| Medications | Neuroleptic medications (*n* = 6) |
| | Antidepressants (*n* = 2) |
| Mean age at time of diagnosis | 23.3 yr |

## Data Collection

I conducted individual interviews with the participants over a 3-week period. A few of the participants worked during the week, so I conducted the interviews at times that accommodated their schedules. I conducted all interviews in a private area at the residential facility. Each interview lasted from 45 minutes to 1 hour. I asked the participants for permission to use a digital tape recorder to capture their interview responses, and I took notes during the interviews. As already mentioned, I obtained signed consent from all six participants prior to conducting the interviews. There were no variations to the data collection plan that I explained in Chapter 3. I did not encounter any unusual situations during data collection.

The participants’ behaviors were appropriate during the interviews. I asked open-ended questions to better understand the participants’ backgrounds and any negative experiences that they may have encountered when seeking mental health services. I designed the interview items to help me understand the barriers that African Americans may face when seeking treatment for schizophrenia. After each interview, I thanked the participant for participating in the study. I saved a transcribed copy of each interview to a password-protected file on my computer.

## Data Analysis

My intent in conducting this study was to obtain a deeper understanding of the complex realities of living with and being hesitant to seek treatment for schizophrenia experienced by the participants. As part of the data analysis, I read all six transcriptions and removed statements that did not relate directly to the phenomenon under investigation.

I conducted a detailed line-by-line analysis of the participants’ interview responses to break the data into segments in order to interpret them. I used NVivo coding to assign labels to responses with similarities or patterns directly related to answering the RQ (Bazeley, 2013). I remained unbiased and opened minded during this process. Categories were assigned to the data as I looked for patterns to emerge. During this process, I approached the interview questions and identified if the core content verified an exact theme or trend that needed to be isolated.

Because of the small sample size, I followed a hand-coding approach (Bazeley, 2013). I transcribed the taped interview responses verbatim, and I reviewed my field notes to ensure no discrepancies during data collection and analysis. Hand coding allowed me to develop as many themes as possible (Bazeley, 2013). Five themes emerged from similarities among the participants' responses.

As previously mentioned, I collected the data by conducting semistructured interviews with the six participants. I designed the interview items to identify the reasons for the underuse of mental health services by members of the African American community diagnosed with schizophrenia. I prepared a prompt sheet with the five interview items in advance for the interviews. Biggerstaff (2009) urged that the questions be prepared beforehand so that researchers can take the lead during the interview process. All questions were open ended to encourage the participants to share details about their feelings, attitudes, and understanding of the phenomenon (Creswell, 2012).

Biggerstaff (2009) also noted that the use of a recorder ensures that the participants' statements will be transcribed accurately. Using these transcriptions and recordings, I conducted an analysis of the transcriptions, written notes, and recordings. I also noted important statements and key words. I read and reread each transcription several times to grasp the full meaning of each statement in relation to the transcription as a whole. I considered the field notes and recordings after all interviews in the final analysis.

Use of a phenomenological research design was appropriate to meet the purpose of the study. Conducting in-depth interviews allowed me to explore the lived experiences of a sample of African Americans diagnosed with schizophrenia and the reasons for their underuse of mental health services. According to Creswell (2012), a phenomenological design provides a platform to give voice to individuals who are affected directly by the phenomenon to describe their lived experiences.

I chose a phenomenological approach to identify themes associated with the barriers that contributed to the participants' underuse of mental health treatment. To provide appropriate mental health treatment to African Americans diagnosed with schizophrenia, it is essential to recognize their ability to emphasize their independence and appreciate their viewpoints of themselves as exceptional. Furthermore, concerning managing symptoms, it is crucial to understand that although they may not be free of delusions and hallucinations, they still may be at their best state of mental wellness. At the time of the study, all participants were compliant with their medication protocols and were free of alcohol and drug use.

## Issues of Trustworthiness

Creswell (2007) stated that study participants who have been interviewed must be given the opportunity to read their individual transcriptions to ensure their accuracy. Creswell (2012) also noted that researchers who conduct interviews must be aware of and address any personal biases that could taint their findings. To support the reliability of the current study, I set aside personal biases and analyzed the data to capture the true experiences of the participants. I allowed the participants to read my transcriptions of their interview responses and listen to their voice recordings to ensure accuracy. I also ensured trustworthiness throughout this study by adhering to the research and interview protocol approved by Walden University's IRB.

# Interviews

## Participant 1

Participant 1 was a 38-year-old African American man from South Carolina. He was slender, well spoken, and neatly dressed. I asked him to tell me where he had been raised and who had raised him. He stated that he had been raised in a two-parent household. He had burns over 40% of his body. I asked him how he got those burns.

He explained:

> When I was 5 years old, my father asked me to hold a gas can full of gasoline. I don't know how it caught fire, but it did, and so did I. I was in the hospital for over a month. He stated that it was his fault that he was burned. His father had told him to stand still, but he bent over to pick something up, and the gas can exploded.

I asked him if he could tell me a little bit more about himself. He responded, "I have high school diploma, and I enjoy writing poetry. I have never been married; I have a 9-year-old daughter, and we have a good relationship."

He reported having trouble focusing in high school. He stated that he had his first auditory hallucination in high school when he was 16. He did not reveal the content of those voices. Since then, he said that he has continued to hear special messages coming from the television set or animals.

I asked him if he was employed, and where. He stated that he worked at Olive Garden and spent time with his daughter when he could. He also shared, "Sometimes I do other stuff," but he would not elaborate.

When asked if he perceived himself as being different from others, he stated, “Of course I’m different [laughing] from others. I deal with a lot of mood swings and stuff.” He described his treatment for schizophrenia as “everything is good when I take my medicine; I’m calm. I don’t tell people I take that kind of medication.”

I asked him if he had missed any of his mental health appointments and if so, why. He said, “I have missed a lot of mental health appointments. I don’t drive, so I have to take the bus over there, and sometimes, the buses don’t come.”

I then asked him if he had had any negative experiences in treatment or trying to seek treatment. He responded, “No, I don’t think so. I wish my doctor understood how I feel.” When I asked him what he meant by that, he said, “Never mind.” The interview ended, and I thanked him for taking the time to answer all of my questions.

### Participant 2

Participant 2 was a 32-year-old African American man who was 6 feet 2 inches tall. He was well dressed and slightly overweight. I asked him if he was ready to begin the interview, and he answered, “This won’t take long, will it?” I reassured him that he could stop the interview at any time. After nodding that he understood, we began the interview.

I asked him to tell me where he had been raised and who had raised him. He shared, “I was raised by my mother and never knew my father.” He said that not knowing his father has caused him to be depressed during his life. He explained, “I know my dad is dead, but I still wonder why he never wanted to know me.” He revealed that he had one son and tried to be a good father.

He stated that he had never married. When I asked about his work status, he said, “I was bullied all my life because I was in special education. I received a certificate for graduating from high school. It ain’t good for nothing, so I do mechanic work.”

When I asked him to describe a typical day, he provided the following details:

> On a typical day, I get up in the morning, take my pills, and go to work. After work, I go to the house where I live. They make me go to meetings, so today, I’ll go to a meeting.

I asked what kind of meetings he attended. He responded that he attended AA (Alcoholics Anonymous) or NA (Narcotics Anonymous) meetings. When I asked him what he did after the meetings, “I eat and go to sleep. That’s about it.” When asked if he perceived himself as being different from others, he stated that he sometimes felt different because he had a special gift. He explained that he could hear and see things that other people could not. I asked him about what kind of things, and he said, “I can’t tell you.”

I asked him to describe his treatment for schizophrenia. He commented:

> It was okay. The doctor gave me pills when I was in jail. They said I have schizophrenia. They said that’s what’s wrong with me. I don’t tell people that. I keep it to myself because people treat me bad when I tell them I take that kind of medicine.

I asked him what he went to jail for. He reported, “I shot my girlfriend. She kept bothering me. I asked her to stop, but she kept breaking windows at my mother’s house. I guess she okay. I don’t see her anymore.”

According to Participant 2, he could not remember how many mental health appointments he had missed, but he believed that it might have been eight or nine. He stated, “I don’t have a car, so it’s hard to get there sometimes.”

At the end of the interview, I asked if he had had any negative experiences in treatment or trying to seek treatment. He replied, “Well, not really. It’s just that sometimes they talk to you like you [*sic*] stupid or can’t understand, and that piss me off, but the new doctor over there at mental health is a little better.” I ended the interview and thanked him for participating in the study.

### Participant 3

Participant 3 was a 42-year-old African American man. I reintroduced myself to him and asked if he was ready to begin the interview. He said that he was ready. I asked him if he wanted to tell me a little bit about himself. He said that he had been born in Kentucky and had been raised by his mother, a social worker, and father, a math teacher. He shared that he had two children and had been married twice. He reported that when he came home from work one day, his house was empty and his second wife and children had left. He stated, “That was the last time I saw them.”

He stated that his wife had left him because he was building an altar in the backyard so that he could sacrifice raccoons and possums to God. I asked about his first wife, but he did not want to talk about her. He stated that he had earned an associate’s degree and was working as a construction worker at the time of the study.

When I asked him to tell me about a typical day, he stated:

> I don’t work right now, so I go sit at the temp agency down the street to see if they got work for me. If not, I go back to the home and read a book in my room until it’s time to eat or go to a meeting. Then I go to sleep. I stay out them streets now ’cause that’s how I stay in jail and in trouble and I’m done with that.

When I asked him if he perceived himself as different, he responded, “Yes, but I keep it to myself. Last time I told them boys, they looked at me like I’m crazy. They were real jokey with me at the last house, so I left.”

When I asked Participant 3 to describe his treatment for schizophrenia, he said, “Well, in high school, I was huffing gasoline. People say I was acting funny. I started seeing things, and that’s when I got my gift.” He reported that his gift was seeing God and God telling him to do things.

I asked him about the things that God wanted him to do. He explained:

> He told me to build an altar in my backyard and sacrifice raccoons and possums. My father took me to a doctor, and the doctor said I have schizophrenia. I don’t tell everyone about my gift ’cause they make fun of me. I take a lot of stuff, but I still have my gift, and I don’t have an illness.

I asked him if he had missed any mental health appointments and if so, why. He reported that where he was living, he could catch a ride. Before that, he missed them all because “ain’t no bus route over there in West Ashley. Now I don’t miss too much.”

For my last question, I asked him if he had ever had any negative experiences in treatment or trying to seek treatment. He answered:

> Well, I'll try to tell the truth. Over at Trident Hospital, them people treat you any kind of way. They think I'm crazy just 'cause I take these pill, but I ain't crazy now. At MUSC, they treat me a little better over there, but it's far from the house, and I don't always have money to go there. So I just deal with it 'cause I know I'm going to jail if I don't take my medicine and I'm trying to stay out that place.

At this time, the interview ended, and I thanked him for his participation.

**Participant 4**

Participant 4 was a 41-year-old African American woman. She was neatly dressed and seemed nervous. Once we began the interview, I asked her if she would like to share some things about herself. She replied, "Like what?" I mentioned that she might want to tell me where she had been born, if she had ever married, and if she had ever had children.

She shared the following details:

> Sure, I can tell you that. I was born and raised in South Carolina. I did not finish Grade 8, and I never married. I have four children; all of my children were put up for adoption because of my drug habit. I was raised by my aunt and don't remember my mother or father.

She reported that she had always had trouble concentrating. She admitted to using street drugs as early as 14 years of age. She also reported that she had become a prostitute to support her crack habit. As she explained, "Crack helped me to deal with the voices in my head."

She stated she had been arrested for prostitution when she was 18 years old and that it was while she was in jail that she had been diagnosed with schizophrenia. With a smile on her face, she said, “I have not been arrested since 2016, and I’ve been taking my medication only because it was court ordered.”

When I asked her to tell me about a typical day, she answered, “Well, for me, it is based on problem solving when it comes to my life and living skills,” but then she changed the subject and started to talk about her children, mentioning that “I wonder what they are doing. Are they alive or dead? I think about that every day. The voices tell me [that] they are looking for me.” When I asked her if the voices told her anything else, she said, “Yes, sometimes they tell me that medicine is making me sick.” She added,” I don’t tell nobody I take medication. People laugh at you.”

I then asked her if she perceived herself as being different from others. She replied, “Yes, at times I do, but I realize I’m my parent child.” I asked her what she meant by being her parent child. She answered, “I’m not sure.”

I asked her to describe her treatment for schizophrenia. She said that she received treatment from the state’s mental health facility and was pleased with her treatment. When I asked if she had missed any appointments and if so, why, she stated, “Yes, I’ve missed several appointments because I don’t have transportation and buses don’t run all the time out here.” She reported missing at least six appointments and was “afraid to miss any more because I’m court ordered to comply with treatment.”

I told her that I had one last question. She said, “You can ask your question.” I asked her if she had had any negative experiences when trying to seek mental health treatment. She responded, “Well, in the past, but not anymore.” At the conclusion of the interview, I thanked her for her participation.

**Participant 5**

Participant 5 was a 55-year-old African American woman. She had a neat appearance, and her hands were folded firmly in her lap. She spoke in a low tone. I asked if she could tell me a few things about herself.

She shared some details:

> Sure, I was born in South Carolina, and I have been here all my life. I have two daughters, but I have not seen them in 3 years. My mother died when I was 12 years old, and I never knew my father.

What asked about school, she said that she had dropped out of high school in her second year. She left school because “it was just too hard and I had no friends.”

She leaned forward and tearfully told me, “I wasn’t really going to stab my daughter. I picked up the butcher knife to scare her. I really miss them. I’m so sorry I did that.” I asked her if she wanted to continue, and she said that she did.

Participant 5 had been diagnosed with schizophrenia when she was 23 years old. She stated that she had always been able to talk to the dead, mentioning, “Sometimes, the dead come to me, like when I be sleeping.” When I asked her to tell me about a typical day, she replied, “I go to the restroom, take my shower, and brush my teeth. I go back in my room and wait for breakfast.”

She noted, “I never been able to keep a job because the dead come to me at work and I talk to them and people make fun of me. So I always get fired.”

I asked if she perceived herself as being different from others, and she responded:

> I am different. I can talk to the dead, and other people can't I'm never alone; they always there. When people are around, I don't talk back, because I don't want nobody to know about my gift. The medication make[s] them go away sometimes, and I don't like that.

When I asked her how she would describe her treatment for schizophrenia, she said, "I don't know. I am satisfied. Yes, I am."

When I asked her how many mental health appointments she had missed, and why, she explained:

> I don't remember 'cause I thought I didn't need to go when I was at home. I just moved here and to stay in this program, I have to keep my appointments. When I take medication, the dead don't talk to me as much. I don't like that.

When I asked if she had had any negative experience in treatment or when trying to seek treatment, she said, "Yes, I can't drive, and sometimes it's hard to get transportation, but here, staff will take me." I asked her if she wanted to add anything else, but she answered, "No that's enough." The interview ended, and I thanked her for answering my questions.

## Participant 6

Participant 6 was a 29-year-old African American woman. She was neatly dressed in men's' clothing. I started the interview by asking her to tell me about herself.

She provided the following details:

> I was born and raised in South Carolina. I lived with my mother. My father left us when I was 10 years old. I lived in a rural area of South Carolina and had trouble making friends. I have never been married, and I don't have kids.
>
> She [laughing] said, "Men ain't my thing, I like girls."

She reported graduating from high school while attending special education throughout her school years. She did not have a college education. She reported that she had never been able to "hold a job."

When I asked her to describe a typical day, she answered, "I start my day with breakfast and a shower. Then I go outside and sit for a [little] while. Then I take a nap. Next, we have lunch, and I just hang out until dinner."

I asked what hanging out meant to her. She explained, "I just walk to the store or just walk around the neighborhood looking around."

When I asked her if she perceived herself as being different from others, she replied, "Sometimes I do because the voices in my head tell me otherwise. Like I'm a superhero. I feel special and happy. I don't tell everybody, because when I used to, they didn't get it and thought I was crazy."

When I asked her to describe her treatment for schizophrenia, she said, "It's not all that, the medications don't work or maybe, I should give it time. I don't think I even need to take that stuff."

When I asked her if she had missed any mental health appointments and if so, why, she shared, “I missed like seven appointments in the past due to the fact that I didn’t have transportation.”

For my last question, I asked her if she had had any negative experiences when seeking mental health treatment. She noted, “I have had many negative experiences with seeking treatment. My counselors weren’t very understanding about trying to find me a place to live, and my doctor never listened when I told him something was wrong with the medicine.” The interview ended, and I thanked her for her participation.

## Results

The six participants who initially volunteered for the study were retained in the sample. They were required to sign the consent form prior to the interview, and I explained the study in depth to them before they signed the consent. The ages of the participants at the time of the original diagnosis of schizophrenia ranged from 16 to 25 years ($M$ = 23.3 years). All participants had to complete a standard screening protocol questionnaire before being accepted for the study. The real names of the participants were not used in an effort to maintain their privacy and the confidentiality of their interview responses. I referred to them by numbers (e.g., Participant 1). All six participants were African American men ($n$ = 3) and women ($n$ = 3) between the ages of 29 and 55 years. All participants were receiving psychiatric outpatient care and were taking some type of neuroleptic medication at the time of the study. Following are discussions of the five themes that emerged from the analysis of the interview transcriptions.

### Theme 1: Lack of Transportation

All participants reported the lack of transportation as a major reason for missing mental health appointments. In response to the interview question (i.e., How many mental health appointments have you missed, and why?), Participant 1 said, “I don’t drive, so I have to take the bus over there, and sometimes, the buses don’t come.” Participant 2 shared, “I don’t have a car, so it’s hard to get there sometimes.” Participant 3 reported that where he was living, “I can’t catch a ride [and] before that, I missed them all because “no bus route over there in West Ashley.” Participants 4, 5, and 6 cited the lack of transportation as the main reason for missing mental health appointments.

### Theme 2: Viewed Hallucinations/Delusions as a Gift

All six participants reported having gifts related to schizophrenia. According to Participant 1, “Of course I’m different.” Participant 2 said, “I feel different because I have a special gift.” He explained that he could hear and see things that other people could not. Participant 3 stated, “Yes, but I keep it to myself. Last time I told them boys, they looked at me like I was crazy.” Participant 4 responded, “Yes, at times I do, but I realize I’m my parent child.” Participant 5 insisted, “I am different. I can talk to the dead, and other people can’t.” Participant 6 stated, “Sometimes, I do [feel different] because the voices in my head tell me otherwise. Like I’m a superhero. I feel special and happy.”

### Theme 3: Feeling Misunderstood By Their Doctors

I asked the participants if they had had any negative experiences when trying to seek mental health treatment. Participant 1 stated, “No I don’t think so. I wish my doctor understood how I feel.” Participant 2 said, “Well, not really. It’s just that sometimes they talk to you like you stupid, and that piss me off." Participant 3 shared, "Well, I'll try to tell the truth. Over at Trident Hospital, them people treat you any kind of way. They think I'm crazy just 'cause I take theses pill, but I ain't crazy now." Participant 4 remarked, "Well, in the past, but not anymore." Participant 5 associated the lack of transportation to the negative experience of trying to seek mental health treatment. Participant 6 reported, "My counselors weren't very understanding about trying to find me a place to live, and my doctor never listened when I told him something was wrong with the medicine."

### Theme 4: Keeping Their Illness Hidden From Others

Participant 1 stated, "I keep it to myself." Participant 2 reported, "I keep it to myself because people treat me bad when I tell them I take that kind of medicine." Participant 3 stated, "I don't tell everyone about my gift 'cause they make fun of me." Participant 4 said, "I never been able to keep a job because the dead come to me at work and I talk to them and people make fun of me." Participant 5 reported "Nobody knows I take medication." Participant 6 explained, "I don't tell everybody, because when I used to, they didn't get it and thought I was crazy."

### Theme 5: Questioning Whether They Really Needed Medication

Participants 1 and 2 did not complain about their mental health medications or deny that they had schizophrenia. Participant 3 was court ordered to comply with her mental health treatment. Participant 4 also was court ordered to comply with treatment if she wanted to continue to live at the independent facility, even though the medication made her sick. Participant 5 stated that she was court ordered to comply with treatment.

Participation 6 mentioned that her medication was not working while suggesting that maybe she not given it enough time.

## Answers to the Research Question

The six interviews provided relevant data that answered the RQ. Following are the findings as they related to the RQ, which sought to identify the barriers influencing the underuse of mental health services by African Americans diagnosed with schizophrenia. All participants reported the lack of transportation as the main reason for missing mental health appointments. All participants perceived themselves as having a special gift or being different from others, neither of which they linked to schizophrenia. Even though they perceived themselves as having a gift or being special, they did not tell others because they feared the negative responses of peers and their treatment from them.

Two participants were court ordered to comply with treatment, but one participant complied only to stay in a housing program. According to one participant, taking medication kept him calm; the other participant did not have any complaints. Five participants reported lacking respect from mental health professionals and feeling misunderstood and not being heard by them as problems. Four participants questioned whether they really needed to take their medication. I asked the participants to tell me about a typical day in their lives to help to establish rapport with them. My primary focus was to answer the RQ.

## Summary

In Chapter 4, I described the data collection, data analysis, and verification of data processes. I presented the findings as they related to answering the RQ. Fleurantin (2013) and Snowden (2012) suggested that racial and ethnic minorities in the United States are more likely to underuse mental health services or impulsively terminate treatment, despite the continued need for treatment. Addressing the barriers influencing African Americans' underuse of mental health services might help clinicians to find solutions.

Five themes emerged from the analysis of the participants' responses to the interview questions. They viewed the lack of transportation as a problem when trying to comply with mental health treatment. They also viewed their schizophrenia symptoms such as hallucinations and delusion as a gift. Because they viewed their symptoms as a gift, the participants questioned whether they really needed to take their medication. They also felt that their mental health doctors misunderstood them and did not respect them. Fearing rejection from peers, they keep their illness a secret.

The findings confirmed the lack of trust, respect, and understanding of mental health treatment by clinicians as important barriers to the willingness of African Americans diagnosed with schizophrenia to seek treatment. In Chapter 5, I provide an overview of the study and an interpretation of the findings. I also discuss the implications for social change, offer recommendations for future research, and provide a brief conclusion.

# Chapter 5: Recommendations and Conclusions

This final chapter summarizes the findings of this research project. The purposes of this chapter are to present and discuss the conclusions, outline the implications of the study, present the limitations of the study, and identify areas for future research. This study was undertaken within a phenomenological context to understand the experiences of a sample of six African Americans who had been diagnosed with schizophrenia. I used a method outlined by Creswell (2012) and Van Manen (1997). The purpose of the study was to explore the lived experiences of African Americans who had been diagnosed with schizophrenia and identify the reasons for their underuse of mental health services.

Fleurantin (2013) and Snowden (2012) suggested that racial and ethnic minorities in the United States are more likely to underuse mental health services or impulsively terminate treatment, despite their continued need for treatment. I sought to identify the barriers influencing African Americans' underuse of mental health services. Three African American male and three African American female participants were recruited from an independent living facility to be in the study. All participants had previously received a diagnosis of schizophrenia and were actively taking their medication and attending some type of support group at the time of the study.

## Findings

The RQ (i.e., What barriers influence the underuse of mental health services by African Americans with schizophrenia?) was used to develop the five interview items:

1. Tell me about a typical day.
2. Do you perceive yourself as being different from others?

3. How would you describe your treatment for schizophrenia?
4. How many mental health appointments have you missed, and why?
5. Have you had any negative experiences in treatment or trying to seek treatment?

After collecting the data, it was analyzed. Five themes emerged from that analysis:

Theme 1. All participants reported the lack of transportation as a major reason for missing mental health appointments. All participants vocalized lack of transportation as a negative experience when trying to seek mental health treatment. According to research conducted by (Conner et al.,2010). transportation was identified as a major barrier for African Americans seeking mental health treatment and missing appointments. In addition, to transportation 23 participants citied finances and a lack of insurance as significant issues for seeking mental health treatment.

Theme 2: All participants reported having gifts related to schizophrenia.

Theme 3: All participants felt misunderstood by their doctors whether they thought that they were being given the wrong medication or just not being heard. They also felt that their mental health doctors did not respect them.

Theme: 4. Even though they perceived themselves as having a gift or being special, they did not tell others because they feared the negative responses or treatment from peers. Fearing rejection from peers, they keep their illness a secret.

Theme 5: Because they viewed their symptoms as a gift, the participants questioned whether they really needed to take their medication.

I followed a phenomenological approach to explore the feelings, beliefs, and attitudes of the six African American participants, all of whom had been diagnosed with schizophrenia, to understand their underuse of mental health services. Creswell (2012) argued that a phenomenological research method offers a flexible and available approach to understand the lived experiences of human behavior. This approach was intended to obtain in-depth accounts of the participants' experiences.

Biggerstaff (2009) outlined the ways that this approach can give researchers the opportunity to develop an idiographic understanding of their participants' lifestyles and environments within their social realities. According to Creswell (2012), a phenomenological approach allows researchers to study the participants' personal lived experiences. Creswell noted, "It produces an account of lived experience in its own terms rather than one prescribed by pre-existing theoretical preconceptions" (p. 181).

The theoretical framework for this research was SDT, developed by Ryan et al. (2000). Mancini (2008) described SDT as a widely researched and empirically validated theory of human need and fulfillment. SDT focuses on the three basic human needs of autonomy, self-esteem, and respect.

The findings confirmed the lack of trust, respect, and understanding by mental health treatment clinicians as important barriers to the willingness of African Americans diagnosed with schizophrenia to seek treatment. Transportation played a major role in participants' inability to kept mental health appointments. Trustworthiness as it pertains to the study was valid. The participants were given the opportunity to read their responses and note any inaccuracies in the transcriptions. They also were given copies of their own interview responses.

## Limitations of the Study

The results were based on the analysis of the responses from a small sample of six participants. The study also was restricted to individuals residing at an independent living facility at the time of the study. According to Marshall and Rossman (2006), all research designs have flaws. Even though a qualitative study design offers numerous advantages when exploring the lived experiences of the participants, it still has some limitations. The sample in my study comprised six African American participants recruited from the southeastern region of the United States. Because of the small target population and the participants' residence in a rural area, the results may not be generalizable to other African Americans in populations in other regions, possibly limiting transferability.

In addition, dependability is contingent upon the ability of other researchers to replicate the participants' responses. Consequently, dependability may have been an issue. It is possible that because the semistructured interview items were written, a different researcher might be able to attain parallel results, given that the exact same initial interview items are being asked.

## Recommendations

As the researcher, I conducted this study without any predetermined biases. I had no personal agenda regarding the outcomes, and I was interested only in identifying the barriers influencing the underuse of mental health services by African Americans with schizophrenia. The potential for bias was present because the participants and I are African American individuals. In addition, I considered that my words or body gestures might have influenced the participants' responses, albeit unintentionally. These factors were considered prior to conducting the interviews. I had no influence over the participants' responses to the interview questions. I prepared the interview items beforehand and asked them in the same order for all participants.

One recommendation for future research is to recruit participants who have different levels of education to determine if education might be a factor in how well African Americans diagnosed with schizophrenia respond to mental health treatment. Another recommendation is to recruit participants who are residing in urban areas, but not independent living facilities, and have easy access to transportation. Results could be compared to see if location is a factor in the delivery of quality mental health treatment to African Americans. The third recommendation is to include participants who have not been court ordered to take their medication. The last recommendation is to include only participants whose primary mental health physicians are African Americans as one way to eliminate bias as a factor.

## Implications

Earlier researchers mentioned in this study have emphasized that African Americans do not seek or stay in mental health treatment at the same rates as European Americans do. When African Americans do seek help, they tend to terminate sessions prematurely because of their discontent when dealing with European American clinicians (Alvidrez et al., 2010). Possible implications for social change at the individual and community levels are that African Americans could have better access to and opportunities to receive mental health services. Access includes transportation in rural areas.

According to Snowden (2012), African Americans would have more opportunities to receive help if European American clinicians would form a therapeutic alliance with them without bias. European American clinicians must set aside stereotypical or biased views that they may have about African Americans, when they are interacting in therapeutic interactions with them. Without checking their biases when seeing African American patients, there is scant likelihood of a therapeutic alliance because rapport was not established (Snowden, 2012).

If African Americans were to have better mental health treatment experiences, they might feel stronger not only as individuals but also as families (Fralich-Lesarre, 2012). They also may have more positive experiences with mental health clinicians. Fleurantin (2013) conducted a phenomenological study of African Americans' underuse of mental health services and identified a knowledge gap concerning their lack of use of the services. Having a better understanding of the needs of African Americans might help to close the gaps in previous research and result in successful therapeutic outcomes for African Americans diagnosed with schizophrenia.

## Conclusion

The purpose of this study was to explore the lived experiences of African American individuals living with schizophrenia and identify the reasons for their underuse of mental health services. Results identified several factors for their underuse of mental health services. The lack of transportation was identified as the primary reason for missing mental health appointments. Historical racial dyads did not seem to play a role in missing appointments.

Past researchers have outlined disparities in the mental health care of African Americans. Aggarwal and Mosca (2010) reported that nonadherence to antipsychotic medications has been associated with an increased number of hospitalizations of African American with schizophrenia, higher hospital costs, and more emergency room visits. Further study is warranted to explain the underuse of mental health services by African Americans and their nonadherence to prescribed medications. Results confirmed the lack of transportation, along with the lack of trust, respect, and understanding by mental health treatment clinicians as important barriers to the willingness of African Americans diagnosed with schizophrenia to seek treatment.

# References

Aggarwal, B., & Mosca, L. (2010). Lifestyle and psychosocial risk factors predict non-adherence to medication. *Annals of Behavioral Medicine, 40*(2), 228-233. doi:10.1007/s12160-010-9212-6

Alexander, M. (2012). *The new Jim Crow: Mass incarceration in the age of colorblindness.* New York, NY: New Press.

Alvidrez, J., & Snowden, L. R. (2009). Psychoeducation to address stigma in Black adults referred for mental health treatment: A randomized pilot study. *Community Mental Health Journal, 45,* 127-136. doi:2021876910.3109/0161284090334226

Alvidrez, J., Snowden, R. L., & Patel, G. S. (2010). The relationship between stigma and other treatment concerns and subsequent treatment engagement among Black mental health clients. *Mental Health Nursing, 31*(4), 257-264. http://dxdoi.org10.3109/01612840903342266

Amador, X. (2010). *Poor insight in schizophrenia: Implications for diagnosis and treatment.* New York, NY: Colombia University, Teachers College.

American Heart Association. (2015). Diabetes and cardiovascular disease screening and monitoring for people with schizophrenia or bipolar disorder. Retrieved from www.heart.org/heartorg/

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Anderson, L. B. (2011). African American males diagnosed with schizophrenia: A phenomenological study. *Mental Health Nursing, 35*(8), 580-587. http://dx.doi.org/10.3109/01612840.2013.867464

Aveyard, H. (2010). *Doing a literature review in health and science care: A practice guide* (2nd ed.). New York, NY: Open University Press.

Baldwin V. D. (2003). Primitive mechanisms of trauma response: An evolutionary perspective on trauma-related disorders. *Neuroscience & Biobehavioral Reviews, 37*(8), 1549-1566.

Barnes, A. (2008). Race and hospital diagnoses of schizophrenia and mood disorders. *Social Worker, 53,* 77-83. doi:10.1093/sw/53.1.77

Bazeley, P. (2013). *Qualitative data analysis: Practical strategies.* Thousand Oaks, CA: Sage.

Biggerstaff, D. L. (2009). Qualitative research in psychology. In G. Rossi (Ed.), *Psychology: Selected papers* (pp. 175-206). Rijeka, Croatia: InTech.

Britt, R. (2009). A study in nature: The Tuskegee experiment and the new south plantation. *Journal of Medical Humanities, 30,* 155-171. doi:10.1007/s10912-009-90864

Buchanan, R., Kreyenbuhi, J., & Kelly, D., Boggs, D., Noel, M. J., & Fischer, A. B. (2009). The 2009 schizophrenia PORT psychopharmacological treatment recommendations and summary statements. *Schizophrenia Bulletin 2009, 36*(1), 94-103.

Burdick, K. E., Ketter, T. A., Goldberg, J. F., & Calabrese, J. R. (2015). Assessing cognitive function in bipolar disorder: Challenges and recommendations for clinical trial design. *Journal of Clinical Psychiatry, 76*(3), e 342-350. doi:10.4088/JCP.14cs09399

Burton, N. (2015). *The meaning of madness* (2nd ed.). Chatham, UK: Acheron Press.

Bushe, C. J., Taylor, M., & Haukka, J. (2010). Mortality in schizophrenia: A measurable clinical endpoint. *Journal of Psychopharmacology, 24*(4), 17-25. Retrieved from Google.com

Cabassa, L. J., Ezell, J. M., & Fernández, R. L. (2010). Lifestyle interventions for adults with serious mental illness: A systematic literature review. *Psychiatric Services, 61*(8), 774-782. doi:10.1176/appi.ps.61.8.774

Chao, R. C. L., Mallinckrodt, B., & Wei, M. (2012). Co-occurring presenting problems in African American college clients reporting racial discrimination distress. *Professional Psychology Professional Psychology: Research and Practice, 43*(3), 199-207. http://doi.org/10.1037/a0027861

Coates, T. (2014). The case for reparations. *Atlantic, 313*(5), 54-71. Retrieved from http://www.theatlantic.com/

Conner, T. S., Tennen, H., Fleeson, W., & Barrett, L. F. (2009). Experience sampling methods: A modern idiographic approach to personality research. *Social and Personality Psychology Compass, 3*(3), 292-313. doi:10.1111/j.1751-9004. 2009.00170.x

Copeland, W. E., Shanahan, L., Davis, M., Burnes, B. J., Angold, A., & Costello, E. J. (2015). Increase in untreated cases of psychiatric disorders during the transition to adulthood. *Psychiatric Services, 66*(4), 397-403. http://dx.doi.org/10.1176/appi.ps201300541

Crenner, C. (2011). The Tuskegee Syphilis Study and the scientific concept of racial nervous resistance. *Journal of the History of Medicine and Allied Sciences, 67*(2), 244-280. https://dx.doi.org/10.1093/jhmas/jrr003

Creswell, J. W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W., & Clark, L. P. (2007). *Designing and conducting mixed methods research* (2nd ed.). Thousand Oaks, CA: Sage.

Cross-Disorder Group of the Psychiatric Genomics Consortium. (2013). Identification of risk loci with shared effects on five major psychiatric disorders: A genome-wide analysis. *Lancet, 381*(*98*75), 1333-1430. doi:10.1016/S0140-6736(12)62129-1

Crump, C., Winkleby, M. A., Sundquist, K., & Sundquist, J. (2013). Comorbidities and mortality in persons with schizophrenia: A Swedish national cohort study. *American Journal of Psychiatry, 170,* 324-333.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005). *The Sage handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage

Dohan, F. C. (1966). Cereals and schizophrenia: Data and hypothesis. *Acta Psychiatrica Scandinavica, 42*(2), 125-152.

Dohan, F. C., Harper, E. H., Clark, M. H., Rodriguez, R. B., & Zigas, V. (1984). Is schizophrenia rare if grain is rare? *Biological Psychiatry, 19,* 383-399.

Durbin, A., Rudoler, D., Durbin, J., Laporte, A., & Callaghan, R. C. (2014). Examining patient race and area predictors of inpatient admission for schizophrenia among hospital users in California. *Journal of Immigration Minor Health, 16*(6), 1025-1034. doi:10.1007/s10903-013-9831-7

Eaton, W., Mortensen, P. B., Agerbo, E., Byrne, M., Mors, O., & Ewald, H. (2004). Coeliac disease and schizophrenia: Population based case control study with linkage of Danish national registers. *British Medical Journal, 328*(7437), 438-439. https://doi.org/10.1136/bmj.328.7437.438

Ergün, C., Urhan, M., & Ayer, A. (2017). A review of the relationship between gluten and schizophrenia: Is gluten the cause? *Nutritional Neuroscience: An international Journal on Nutrition, Diet and Nervous System, 21*(7), 455-466. doi.org/10.1080/1028415X.2017.1313569

Fisher, M., Lowery, M., Hardy, K., Schlosser, D., & Vinogadov, S. (2013). Cognitive interventions targeting brain plasticity the prodromal and early phases of schizophrenia: Psychiatry service. *Annual Review of Clinical Psychology, 9,* 435-463. doi:10.1146/annurev-clinpsy-032511-143134

Fleurantin, Y. (2013). *The effects of stigma on health utilization and health outcomes among young adults with chronic depression* (Doctoral dissertation). Available from ProQuest database. (UMI No. 3588963)

Fralich-Lesarre, N. M. (2012). *Beyond cultural competency: Understanding contemporary problems with historical roots using an African-centered/Black psychology lens* (Doctoral dissertation). Available from ProQuest database. (UMI No. 3539696)

Gara, M. A., Vega, W. A., Arndt, S., Escamilla, M., Fleck, D. E., Lawson, W. B., … Strakowski, S. M. (2012). Influence of patient race and ethnicity on clinical assessment in patients with affective disorders. *Archives of General Psychiatry, 69*(6), 593-600. doi:10.1001/archgenpsychiatry.2011.2040

Garcia-Bueno, B., Gassó, P., MacDowell, K. S., Callado, L. F., Mas, S., Bernardo, M., … Leza, J. C. (2016). Evidence of activation of the toll-like receptor-4 proinflammatory pathway in patients with schizophrenia. *Journal of Psychiatry and Neuroscience, 41*(3), e46-e55. doi:10.1503/jpn.150195

Ghimire, S., Casteline, R. L., Lioufas, N. M., Peterson, G. M., Tabish, S., & Zaidi, R. (2015). Nonadherence to medication therapy in haemodialysis patients: A systematic review. *PLOS ONE, 10*(12), e0144119. http://dx.doi.org/10.1371/journal.pone.0144119

Gilleen, J., David, A., & Greenwood, K. (2010). Domains of awareness in schizophrenia. *Schizophrenia Bulletin, 37,* 61-72. doi:10.1093/schbul/sbq100

Hersen, M., & Beidel, D. C. (2012). *Adult psychopathology and diagnosis* (6th ed.). Hoboken, NJ: John Wiley and Sons.

Holthausen, E. (2007). Predictive value of cognition for different domains of outcome in resent onset schizophrenia. *Psychiatry Research, 149*(1), 71-80.

Horvitz-Lennon, M., Volya, R., Garfield, R., Donohue, J. M., Lave, J. R., & Normand, S. L. (2015). Where you live matters: Quality and racial/ethnic disparities in schizophrenia care in four states' Medicaid programs. *Health Services Research, 50*(5), 1710-1729. doi:10.1111/1475-6773.12296

Insel, R. T. (2010). Rethinking schizophrenia: Coving genomics and its application in the practice of medicine. *International Weekly Journal of Science, 468,* 187-193. doi:10.1038/nature09552

Jackson, J. R., Eaton, W. W., Cascella, N. G., Fasano, A., & Kelly, D. L. (2012). *Neurologic and psychiatric manifestations of celiac disease and gluten sensitivity. Psychiatric Quarterly, 83*(1), 91.

Jacob, B. M. (2015). A dangerous method? The use of induced pluripotent stem cell as a model for schizophrenia. *Schizophrenia Research, 168*(1-2), 563-568. http://dx.doi.org/10.1016/j.schres.2015.07.005

Jarosinski, J. M. (2008). Exploring the experience of hallucinations from a perceptive of self: Surviving and preserving. *Journal of the American Psychiatric Nursing Association, 14*(5), 353-362. doi:10.1177/107839030825417

Jimmy, B., & Jose, J. (2011). Patient medication adherence: Measures in daily practice. *Oman Medical Journal, 26*(3), 155-159. doi:105001/omj.2011.38M

Keval, H. (2015). Schizophrenia and psychosis: The magical and troubling disappearance of race from the debate. *British Psychological Society: Diversity and Equality in Health and Care, 12*(1), 6-8.

Lane, C. (2015). Breaking the silence of mental health in the Black community. Retrieved from http://news.emory.edu/

Large, M. M., & Ryan, J. (2014). Disturbing about the risk of suicide and psychiatric hospitals. *Social Psychiatry and Psychiatric Epidemiology, 49*(9), 1353-1355. doi:10.1007/s00127-014-0912-2

Lawson, W. B. (2014). Racial disparities in diagnosis in patients presenting to emergency rooms: Persisting of misdiagnosis? *Comprehensive Psychiatry, 55*(8), E53. http://dx.doi.org/10.1016/jcomppsych.2014.08.026

Liu, Z. L., Liu, J. Z., Liu, P. J., Yang, M., & Kwong, J. (2010). Herbal medicines for viral myocarditis. *Cochrane Database of Systematic Reviews, 11*(7), CD003711. doi:10.1002/14651858.CD003711.pub3

Mahmood, S. S., Levy, D., Vasan, S. R., & Wang, J. T. (2013). The Framingham Heart Study and the epidemiology of cardiovascular diseases: A historical perspective. *Lancet, 383*(9921), 999-1008. doi:10.1016/S0140-6736(13)61752-3

Mancini, A. D. (2008). Self-determination theory: A framework for the recovery paradigm. *Advances in Psychiatric Treatment, 14,* 358-365. doi:10.1192/apt.bp. 107.004036

Marshall, C., & Rossman, G. B. (2006). *Designing qualitative research* (4th ed.). Thousand Oaks, CA: Sage.

Mayo Clinic. (2013). *Healthy heart for life: The Mayo Clinic plan for preventing and conquering heart disease.* New York, NY: Time Home Entertainment.

Metzl, J. (2009). *The protest psychosis. How schizophrenia became a Black disease: Mental health in the African American community.* Boston, MA: Beacon Press.

Mittal, D., Sullivan, G., Chekuri, L., Allee, E., & Corrigan, P. W. (2012). Empirical studies of self-stigma reduction strategies: A critical review of the literature. *Psychiatric Services, 63*(10), 974-981. http://dx.doi.org/10.1176/appi.ps.20110 0459

National Association of State Budget Officers. (2013). *State expenditure report: Examining fiscal 2011-2013 state spending.* Retrieved from http://www.nasbo. org/sites/default/files/State%20Expenditure%20 Report%20%28Fiscal%202011-2013% 20Data%29.pdf

National Alliance on Mental Illness. (2013). *State legislation report: Trends, themes and best practices in state mental health legislation.* Retrieved from https://www.nami. org/.../About-NAMI/.../Reports/2013statelegislationReport find.pdf

National Alliance on Mental Illness. (2015). *Report of the surgeon general. Mental health: A national alliance of mental illness.* Retrieved from http://namh.org/ content/contentgroup/multicultural_support1/face_sheet1/AfricanAmerican_MentalHealth_FactSheet_2015.pdf

National Institute of Mental Health. (2013). Transforming and understanding the treatment of mental illness. Retrieved from http://www.nimh.nih.gov/

National Survey of American Life. (2013). Disaggregating race and ethnicity in research: The case of African Americans and Caribbean Blacks. Retrieved from https://www.youtube.com

Nordentoft, M., Wahlbeck, K., Hallgren, J., Westman, J., Osby, U., Alinaghizadeh, H., … Laursen, T. M. (2013). Excess mortality, causes of death and life expectancy in 270,770 patients with recent onset of mental disorders in Denmark, Finland, and Sweden. *PLOS ONE, 8*(1), e55176. http://dx.doi.org/10.1371/journal.pone.0055176

O'Gorman, C. O., Kapur, S., Kolluri, S., & Kane, J. (2011). Early improvement on antipsychotic treatment as a predictor of subsequent response in schizophrenia. *Human Psychopharmacology: Clinical and Experimental, 26*(4-5), 280-290. doi:101002/hup.1200

Omum, V. W. (2012). Disparities in mental health care for African Americans. Retrieved from http://americanmentalhealthfoundation.org/

*Oxford dictionary.* (2017). Alogia. London, England: Oxford University Press.

Park, S. J., Lee, J. Y., Kim, S. J., Choi, S. Y., Yune, T. Y., & Ryu, J. H. (2015). Toll-like receptor-2 deficiency induces schizophrenia-like behaviors in mice. *Scientific Reports, 5,* 8502. doi:10.1038/srep08502

Pezalla, A. E., Pettigrew, J., & Miller-Day, M. (2012). Researching the researcher as an instrument: An exercise in interviewer self-reflexivity. *Qualitative Research, 12*(2), 165-185. doi:10.1177/1468794111422107

Primm, A. B., Vasquez, M. J., Mays, R. A., Sammons-Posey, D., McKnight-Eliy, L. R., Presley-Cantrell, L. R., … Perry, G. S. (2010). The role of public health in addressing racial and ethnic disparities in mental health and mental illness. *Preventing Chronic Disease, 7*(1), A20.

Rodriguez, F. M. (2011). *Organizational response to address and quality of care issues for limited English proficient (LEP) patient populations* (Doctoral dissertation). Available from ProQuest database. (UMI No. 3616337)

Rodriguez, Y. E. (2014). *Client characteristics in cognitive behavioral social skills training (CBSST): The impact of race/ethnicity and culture on psychosocial treatment outcomes for individuals diagnosed with schizophrenia spectrum disorders* (Doctoral dissertation). Available from ProQuest database. (UMI No. 3621828)

Rubin, J. H., & Rubin, I. (2012). *Qualitative interviewing: The art of hearing data* (3rd ed.). Thousand Oaks, CA: Sage.

Ryan, R. M., Curren, R. R., Deci, E. L., & Waterman, A. S. (2000). What humans need: Flourishing in Aristotelian philosophy and self-determination theory. In A. S. Waterman (Ed.), *The best within us: Positive psychology perspectives on eudaimonia* (pp. 57-75). Washington, DC: American Psychological Association. doi:10.1037/14092-004

Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World Journal of Psychiatry, 4*(4), 133-140. doi:10.4598/wip.v4.14133

Singh, M. M., & Kay, S. R. (1976). Wheat gluten as a pathogenic factor in schizophrenia. *Science, 191*(4225), 401-402.

Snowden, L. R. (2012). Health and mental health policies' role in better understanding and closing African American-White American disparities in treatment access and quality of care. *American Psychologist, 67*(7), 524-531. doi:10.1037/90030054

Tamminga, C. A., & Medoff, D. R. (2000). The biology of schizophrenia. *Dialogues in Clinical Neuroscience, 2*(4), 339-348.

Tarman, V. K. (2015). African American pastors and traditional professional mental health services: An investigation of the influence of worldview on perceptions and engagement. Retrieved from https://books.google.com/

U.S. Census Bureau. (2010). State & county quick facts: Allegany County, NY. Retrieved from http://quickfacts.census.gov

Van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). London, ON: Althouse Press.

Ward, E., Wiltshire, J. C., Detry, A. M., & Brown, L. R. (2013). African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. *Nursing Research, 62*(3), 185-194. doi:10.1097/NNR.0b0 13e31827bf533

Wei, J., & Hemmings, G. P. (2015). Gene, gut and schizophrenia: The meeting point for the gene-environment interaction in developing schizophrenia. *Medical Hypotheses, 64*(3), 547-552. http://dx.doi.org/10.1016/j.mehy.2004.08.011

Weidinger, F., Zill, P., Holler, S., Leitner, B., Yomba-Tchoumkeu, S., & Badescu, O. (2013). Toll-like receptor pathway in schizophrenia: A pilot study. *Brain, Behavior, and Immunity, 29,* S22. https://doi.org/10.1016/j.bbi.2013.01.068

Weiten, W. (2002). *Psychology themes & variations* (5th ed.). Belmont, CA: Wadsworth/Thompson Learning.

Wilkins, E. J., Whiting, J. B., Watson, M. F., Russan, R. J., & Moncrief, A. N. (2012). Residual effects of slavery: What clinicians need to know. *Contemporary Family Therapy: An International Journal, 35*(1), 14-28. doi:10.1007/s10591-012-9219-1

Williams, M. T. (2013). How therapists drive away minority clients. Retrieved from https://www.psychologytoday.com/