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Reluctance to Seek Mental Health Treatment Among African Americans Living in Generational Poverty

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Abstract

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MA, Walden University, 2016

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

African Americans are 20% more likely to experience mental health issues but are the least likely group to seek professional mental health treatment. In addition, African Americans are more likely to experience severe mental health conditions than other races due to a greater risk of homelessness and being exposed to violence. This research study used a phenomenological qualitative methodology to explore the attitudes and lived experiences of 10 African Americans living in generational poverty in inner-city Chicago. The participants provide detailed accounts of their lived experiences with generational poverty, mental health, and the attitudes their family lineage had shared with them regarding professional mental health treatment. This research study is based on social stratification and racial segregation theories which focus on the poverty cycle in poor neighborhoods. Thematic analysis was used to analyze the qualitative data. Using the common sense model to guide analysis, four core themes emerged: coping mechanisms, upbringing, attitude, and religion. Two subthemes were also identified: family involvement and mistrust. All of the participants expressed various levels of reluctance towards mental health treatment based on personal experiences, cultural influence, and coping mechanisms utilized by family members. Reduction in mental health care disparities can restore African Americans' trust in clinicians and encourage African Americans to seek professional mental health treatment when needed. African Americans living in generational poverty may benefit from the results of this study by alleviating the symptoms associated with poor mental health such as psychological distress, severe depressive episodes, poverty, and violence.

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Dedication

This is dedicated to the life and love of my grandmother. My confidant, my hope coach, my laughing partner, and my best friend. I am everything I am because you love me. Thank you.

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Chapter 1: Introduction to the Study

Background

The effects of generational poverty on mental health along with social isolation and distress that is experienced in poor neighborhoods have made it difficult to recover from mental illness (Beeber, 2008; Draine, 2013; Santiago, 2013). Previous studies have addressed factors that lead to the poverty cycle in poor neighborhoods, with income segregation, racial segregation, and a lack of mental health treatment being the primary factors (Kneebone, 2014; Quillian, 2012). The importance of a qualitative research design when conducting social and educational research has been asserted (Alexander, 2017; Erickson, 2011). As such, in this study, a qualitative approach was utilized to conduct personal interviews and field observations to describe everyday life in poor neighborhoods with a focus on mental health strategies.

Generational poverty creates a cycle of disadvantage and African Americans living in poverty are 20% more likely than whites to experience depression, PTSD, and suicide (Cheng, 2016; The National Alliance of Mental Illness, 2018). The National Alliance of Mental Illness, also known as NAMI (2018), also described successful interventions in high-poverty, high-minority neighborhood and correlated the number of deaths per year that are linked to ethnic stratification in the United States (Galea, 2011). The role of childhood poverty and neglect in predicting academic achievement and mental health in adulthood has been addressed in the research (Nikulina, 201; Santiago, 2013). Poverty and neglected mental health in childhood have been linked to post-

traumatic stress disorder (PTSD), depression, criminality, and poor academic achievement (Alisic et al., 2014; Nikulina et al., 2011; Read & Bentall, 2012).

In this chapter, a summary of the current literature on the lived experiences of minorities living in generational poverty, in inner-city Chicago is presented. Additionally, the problem statement, the purpose of the study, and research questions are also presented. The theoretical framework, definitions, limitations, significance, and assumptions about the research study have also been discussed. The chapter concludes with a summary of the main ideas that pertain to the identified research problem.

Problem Statement

In the United States, about 46 million people especially African Americans and Latino are living in poverty (Tomaskovic-Devey, 2019). Out of these, close to 1.6 million people are living in poverty in inner-city Chicago (Quillian, 2012). This has been associated with a lack of social, economic, and educational resources. NAMI (2018) noted that African Americans living in poverty are 20% more likely than whites to experience major depression, attention-deficit/hyperactivity disorder (ADHD), suicide, and PTSD. They are also the least likely to seek professional mental health treatment (NAMI, 2018). Ward (2013) reported tendencies among the African American population to avoid treatment based on the lack of cultural competency among mental health treatment providers, fear of being judged, and limited access to treatment. Other researchers have explored how generational poverty creates a cycle of disadvantage and health disparities that are passed across generations (Cheng, 2016). Children who are born into poverty are more likely to accumulate less wealth to pass on to future

generations and are more likely to suffer from the mental illness experienced by their parents, compared to families with a stable economic lineage. As recently as 2013, the National Institute of Health stated further research was needed to address the gap in the literature on the underlying social and cultural experiences of minorities who are reluctant to seek mental health treatment. Further research is also needed to understand the perspective of minorities who come from a lineage of generational poverty and their attitude toward mental health treatment (Cheng, 2016). The mental healthcare needs of people of color continue to be unmet and there is a gap in the understanding of the cultural and sociopolitical factors that affect minority groups (Association of Black Psychologists, 2012).

Racial and ethnic minorities in the United States have suffused all complementary areas of life. However, the full potential of the U.S. multicultural society cannot be realized for all, until a time when the needs of the racial and ethnic minorities will be met by gaining access to quality health services. According to the Association of Black Psychologists, (2012), the mental healthcare needs of people of color continue to be unmet, and there is a gap in the understanding of the cultural and sociopolitical factors that affect minority groups. Racial and ethnic minorities are less likely to have access to mental health care than whites (Biener & Zuvekas, 2019). Additionally, if they are fortunate enough to receive mental health care, it is often of poor quality. This leads to the racial and ethnic minorities experiencing high poverty levels bearing a greater burden from their unmet mental health needs hence their overall health suffers and reduces their productivity (Biener & Zuvekas, 2019). Other studies have shown that African

Americans are reluctant to seek professional mental health treatment, regardless of their gender or age (Ward, 2013). Their reluctance to seek professional mental health treatment affects well-being, health, and optimal functioning (Eshun & Packer, 2016). However, very few studies have explored the African American's lived experiences toward mental health treatment and generational poverty. Furthermore, no studies have addressed the lived experiences of minorities experiencing generational poverty who are reluctant to seek mental health treatment. Therefore, there is a need for research to understand the perspective of minorities coming from a lineage of generational poverty and their attitude toward mental health treatment (Cheng, 2016).

Purpose of the Study

Poor mental health is a key component associated with generational poverty (Cheng, 2016). Adults who suffer from mental health issues are more likely to have a child with mental health problems (Cheng, 2016). Families that suffer from mental illness have a lower socioeconomic status (SES) than families without mental illness, leading to a decrease in academic success, social achievement, and the ability to become gainfully employed (Cheng, 2016). To help resolve the generational poverty cycle in poor neighborhoods, the cultural norms that have been inherited for addressing mental illness must be dissolved.

Therefore, the purpose of this research study was to explore the lived experiences that contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago. Participants were identified based on their

income level, which is a measure of poverty, must be from a lineage of generational poverty, and must have a reluctant attitude towards professional mental health treatment.

Research Questions

This research study was undertaken to probe more deeply into the lived experiences that contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago. Drawing on the theories of social stratification and racial segregation which focuses on the poverty cycle in poor families, the research study will address the following research question:

Research Question 1–Qualitative: What lived experiences contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago?

Framework

This research study focuses on the lived experiences that contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago. Social stratification and racial segregation are two social theories that focus on the cause of the poverty cycle in poor neighborhoods. Attribution theory conceptualizes mental illness to stigma and lack of access to treatment. Social stratification and racial segregation are also related to mental health because lower socioeconomic status is highly correlated with mental illness and reluctance to seek mental health treatment (Reiss et al., 2019). For instance, the poor and chronically, mentally ill are likely to be identified as a social problem (Generaal et al., 2019).

According to Lasalvia et al (2019), stratification in our societies affects the treatment of mental diseases since there is a lack of equality when caring for the sick.

Social stratification is when people are placed in groups based on their income and social status (Hunt & Ray, 2012; Noel, 1968). They can also be placed in groups based on their mental health. The United States distinguishes groups into three classes: upper class, middle class, and lower class. Dividing a population-based on their social class also divides the population-based on occupation. According to Noel's (1968) social theory, social stratification and the racial divide led to the origin of ethnic stratification. Ethnic stratification is when a minority group is categorized based on their social position, with the group relation being used as major criteria for assigning social positions (Massey & Eggers, 1990). It is based on competition for resources, unequal power, and ethnocentrism.

Exploitation occurs when a social group is deprived of resources produced by another group, which prevents the targeted racial group from realizing the full value of their labor (Massey, 2016). The most extreme form of exploitation in America was slavery, which aided in systematically reducing the investments and resources of African Americans over an extended period. Exclusion occurs when a dominant social group restricts access to a scarce resource to minorities in poor neighborhoods. The exclusion either occurs through blatant denial of access or by exercising monopoly control. Exclusion utilizes racially targeted violence, redlining, and biased marketing to channel African Americans to disadvantaged neighborhoods (Massey, 2016).

According to Massey's (2016) social theory, racial segregation is the major cause of concentrated poverty in Chicago. A series of historical changes led to the ongoing production of poverty in minority communities. The mismatch between skill requirements for jobs in urban areas and the average inner-city worker led to the surge in poverty, and unemployment rates in minority neighborhoods. Once legal segregation declined, middle-class African Americans moved from poor black neighborhoods into white neighborhoods, leaving behind poorer residents in the community.

The social theory consists of the social and behavioral abstractions that perpetuate the cycle of poverty. Behavioral factors tend to structure and condition the environment. Behavioral variables such as crime, substance abuse, single-parent households, and teen pregnancy are just a few dysfunctions that can be viewed as a cultural norm in a poor neighborhood (Grusky, 2014). This theoretical perspective consists of the social and behavioral abstractions that perpetuate the cycle of poverty. Behavioral factors tend to structure and condition the environment. Behavioral variables such as crime, substance abuse, single-parent households, and teen pregnancy are just a few dysfunctions that can be viewed as a cultural norm in a poor neighborhood (Grusky, 2014).

Social stratification and racial segregation focus on how the poverty cycle in poor neighborhoods is the result of a lack of mental health treatment among low-income African Americans that extends across familial generations (Massey, 2016). According to Massey, these social theories also addressed the effects of discrimination and prejudice on people living in poor communities. When poverty is concentrated, the effects of poverty become concentrated as well, leading to a higher concentration of crime, welfare

dependency, substance abuse, and disrupted family life (Pascoe et al., 2016). Collectively, social stratification and racial segregation both help to explain how mental illness and cultural dependency can contribute to generational poverty and income disparities by highlighting the importance of stigma and shame on minorities living in generational poverty (Elliott, 2016). According to Smith et al. (2019), some of the reasons for reluctance towards mental health treatment include societal stigma, the cost of treatment, bias, language barrier, fear, mistrust of treatment, fragmented services, and lack of cultural awareness among the clinicians.

Attribution theory was proposed by Bernard Weiner in 1985 and it is based on the idea that individuals are normally motivated to better understand the environment in which they live (Weiner, 1985). In the current study, the application of attribution theory relates to the search for the reasons why minority groups living in generational poverty are reluctant to seek mental health treatment (see Schomerus et al., 2014). The problem is that the cause of the mental health problem is attributed to the individual rather than to the cause. This is even worse for people facing generational poverty where they are blamed for their suffering and lack of competence in taking care of themselves (Zwickert, & Rieger, 2013). Their mental illness is attributed to dispositional factors and such perceptions then affect their behavior.

Nature of the Study

This research study used a phenomenological qualitative methodology to explore the lived experiences that contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago. This study also

explored any personal experiences with mental health concerns among the participants. Interviews with minorities who are living in poverty add a cultural-relativistic perspective. This helps in understanding the minority behaviors within the context of their culture and the society where they face social stratification and segregation (see Azibo & Amungwa, 2019). Viewing clients' behaviors based on their attitudes and beliefs enhances the clinician's effectiveness with the minority groups with mental health problems. Qualitative research relies on narrative analysis to elicit the thoughts of people whose voices are rarely heard (Erickson, 2011).

A qualitative research design helps describe a problem or condition from the people experiencing it. It helps to provide an in-depth view of the lived experiences of people in poverty-stricken areas who are reluctant to seek mental health treatment (Erickson, 2011). Qualitative research allows the study of the people in their natural setting, helping the researcher to obtain a better understanding of their actions, beliefs, interests, and differences (Erickson, 2011).

Definitions

Poverty: Poverty is a state of deprivation that causes a lack of material possessions or money that is considered socially acceptable (Encyclopedia Brittanica, 2018). In this study, poverty was defined based on the poverty threshold established by the U.S. government.

Generational poverty: Generational poverty is defined as a family that has lived in poverty for at least two generations (Nikulina, 2011). In this study, generational poverty and multigenerational poverty are used interchangeably.

Family poverty: A group of two or more people, one being the head of household, that are related by birth, marriage, or adoption, and live together below the poverty threshold (Logan, 2015).

Neighborhood poverty: Neighborhood poverty is based on a percentage of households that live in poverty within a census tract (Boustan, 2013). In this study, neighborhood poverty, community poverty, and concentrated poverty are used interchangeably.

African Americans: African Americans are an ethnic group in the United States with total or partial African descent. The term primarily refers to the descendants of enslaved Africans in the United States (Akhtar, 2012). In this study, African Americans and minorities are used interchangeably.

Attitudes: Attitudes in psychology refer to the beliefs, behaviors, and emotions toward a particular event, thing, or person (Maio & Haddock, 2010). An attitude is typically the result of upbringing or experience and can strongly influence a person's behavior.

Lived experiences: Lived experiences in psychology are defined as the understanding of the choices, options, and experiences from the research participant's perspective (Given, 2008). These factors often influence a person's interpretation of knowledge (Boylorn, 2008).

Mental illness: Mental illness consists of mental health conditions that affect a person's thinking, mood, and behavior (Draine, 2013).

Mental health treatment: Mental health treatment is a therapy that is provided by a trained mental health professional to help improve a person's well-being (Eshun & Packer, 2016). Mental health treatment also helps an individual explore their feelings, thoughts, and behaviors (Eshun & Packer, 2016).

Inner-city Chicago: Inner-city is a term that refers to the impoverished areas of large cities (Census Bureau Data, 2014). Inner-city Chicago in this study will refer to poor, Black, urban neighborhoods in the city of Chicago.

Assumptions

The first assumption of this study was that African Americans living in generational poverty in inner-city Chicago had similar lived experiences and attitudes toward mental health treatment with other poor African Americans living in other urban settings. It is also assumed that the participants were candid and forthcoming about their familial lineage, attitudes, and lived experiences. To promote thorough and honest interview responses, any identifying information was omitted from the demographic and interview questionnaire.

Limitations

One of the study limitations was the recruitment of participants meeting the basic criteria set before participating in the interviews, whereby some participants may end up providing false information about the family income level. Besides, the willingness of the participants to share genuine experiences about generational poverty within their families may also have posed a great challenge. According to Creswell and Poth (2016), phenomenological studies should have between five to 25 participants while Morse

(2000) suggests at least six participants. Therefore, this study was a phenomenological study, 10 African Americans living in generational poverty were recruited but this sample size is small, and qualitative methodology limits the generalization of study findings to the broader Chicago area and neighborhoods. The participant's responses may differ especially for those who may have sought mental health treatment when it comes to the mental health attitude. Also, the lack of randomization provides less opportunity for the results to be generalized for the American population of African Americans who are not living in generational poverty.

Significance

The research study filled a gap in understanding by focusing on the lived experiences and attitudes of minorities living in generational poverty in inner-city Chicago who have a reluctant attitude towards mental health treatment. Currently, several resources such as welfare, subsidized housing, and medical assistance are provided to help maintain the quality of life for people living in poverty. Lê Cook et al. (2013), highlight the existence of disparities in mental health services for minorities in the United States. Ethnic and racial minorities experience less access to mental health services compared to the majority white population and the little care they may receive is in most cases of very poor quality (Leong & Kalibatseva, 2011). These disparities in mental health care provisions have powerful significance not only to the minority groups but to the entire society. One of the major problems arising from the unmet mental health needs among minority groups is the overall loss of their health and productivity. This is because a lack of mental health treatment is highly disabling and play a significant role in

disability. Over one-third of adults with disabilities and living in poverty-stricken areas in the United States have a mental disorder that contributes to their disability (Scott & Havercamp, 2014). Therefore, this study seeks to explore the lived experiences of minorities experiencing generational poverty who are reluctant to seek mental health treatment.

Forty-six million people, primarily African Americans and Latino live in poverty in the United States. Of the 46 million, close to 1.6 million are living in poverty in inner-city Chicago. The lack of social, economic, and educational resources plays a crucial role in the current poverty rate in the poor neighborhoods of Chicago (Quillian, 2012). Although qualitative studies have addressed the poverty cycle and quality of life, this research will obtain the thoughts and perceptions about mental health treatment among the residents currently experiencing generational poverty, which is vital in resolving the poverty cycle in inner-city Chicago. Therefore, there is a need to identify strategies that seek to improve access to mental health care among minorities as well as improve the quality of care and this would eliminate the disparities in access to mental health treatment for minority groups (McGuire & Miranda, 2008). Besides, encouraging a diverse workforce as well as education for both health care providers and mental health patients could also eliminate the disparities in the provision of mental health care (Kohn-Wood & Hooper, 2014). The primary goal of the study was to obtain perspectives on mental health treatment among residents who are currently experiencing generational poverty.

Summary

This chapter has provided an overview of the proposed research by first providing a brief background to the study topic, a problem statement, and the research questions guiding this study. Based on the problem that this study focuses on providing a solution, the study sought to address the attitudes and lived experiences of low-income minorities who are living in generational poverty and are reluctant to seek professional mental health treatment. The study population was a small group of residents living in inner-city Chicago and the study utilized a phenomenological research method to obtain the lived experiences and attitudes of the participants. The study referenced generational poverty based on the poverty line established for the Chicagoland area. The selected sample of participants was also selected based on the self-certification of the basic criteria that need to be met before participating in the interviews.

The next chapter provides literature about African Americans living in poverty and mental health. The primary components discussed in the literature review include generational poverty, concentrated poverty, reluctance among minorities to seek professional mental health treatment, outcomes for lack of mental health treatment and generational poverty, theoretical considerations, and the perception of poverty as it relates to African Americans in inner-city Chicago.

Chapter 2: Literature Review

The purpose of this chapter is to provide a comprehensive review of the literature on African Americans living in generational poverty who may be reluctant to seek professional mental health treatment. This chapter will also provide a review of the literature on African Americans living in generational poverty that are reluctant to seek professional mental health treatment in inner-city Chicago. This review provides a summary and critique of the current literature and discusses the methods that were utilized for searching databases to gather materials. I also discuss the limitations of the current literature and the theoretical framework that was used for the basis of the study.

Literature Search Strategy

I conducted an extensive search using the American Psychological Association, EBSCO ebooks, SAGE, PsychINFO, Academic Search Complete, National Institutes of Health, PsycCRITIQUES, PsycARTICLES, and the U.S. National Library of Medicine with full-text databases. These databases were chosen because of their focus on mental health, psychology, and generational poverty. Two databases were of particular interest to me: American Psychological Association and PsycINFO. Searches were initially set to recognize studies from the years 2011-2019 to obtain current research, and a comprehensive search to examine the years 1968-2010. Keyword searches included a combination of the following terms: *mental health, poverty, generational poverty, minority, African American,* or *mental health* in conjunction with *lived experiences in inner-city Chicago, attitudes, treatment-seeking for minorities, multigenerational*

poverty, and *reluctance.* For information regarding current estimates of mental illness and generational poverty, I used NAMI (2018) and the United States Census Bureau (2014).

In psychology, research on the ongoing cycle of poverty among African Americans has been studied by many authors (Aliprantis et al., 2011; Kneebone et al., 2014; Quillian, 2012). Additionally, several studies focusing on mental health and poverty predictors for minorities were identified (Gilroy et al., 2015; Nikulina et al., 2011). Other studies have studied the attitudes and disparities in mental health treatment (Galea et al, 2011; Tagler et al., 2013; Wolf, 2007). The success of current coping mechanisms in mental health was also addressed (Comerchero, 2016; Reddick et al., 2011). However, only a few studies in psychology have explored the relationship between African American's attitudes toward mental health treatment and generational poverty. Therefore, this study sought to explore the lived experiences that contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago attitudes.

Poverty

The official poverty threshold is set by the Office of Management and Budget (OMB) in the United States. Poor people are defined as those with income less than that which is sufficient to buy the basic needs. Poverty is complex as the cost of living varies based on several factors such as geographical location. This study will focus on two types of poverty: concentrated poverty and generational poverty.

Concentrated Poverty

Most minorities are living in generational poverty due to family lineage (Snowden, 2014). Although the overall poverty rate in the United States was the same in 2000 as it was in the year 1970, the geographical location of the poor has become more concentrated (Aliprantis & Zenker, 2011). When the poverty rate is categorized by race, the poverty rate for Asians decreased by 12% while the poverty rate for whites has remained the same. However, the poverty rate for Blacks and Hispanics has increased by 27% since 2012 (Reeves et al., 2016). Residents of poor communities have fewer resources and opportunities that affect the outcome and the overall quality of their lives. An individual's social, economic, and educational status are determined by individual factors such as education and social status. A person's upbringing, family lineage, and environment are also shaped by the resources and advantages of the groups that are affiliated within the social circle.

According to Aliprantis et al. (2011), children from poor neighborhoods are more likely to graduate and pursue higher education if they are given a chance to attend school with upper-class children or attend school outside of their concentrated environment. Studies have shown that students who only interact with other poor children are twice as likely to drop out of school or repeat the negative outcomes that are associated with a high poverty lifestyle (Aliprantis et al., 2011).

Census Bureau data (2014) determined variations in poverty rates, based on geographical location. According to Aliprantis and Kolliner (2015), although poverty is measured by a person's income threshold, the effects of individual poverty on a

neighborhood are not considered to be as detrimental as community poverty. If a poor family lives in an upper-class neighborhood, they will have access to better schools and a stronger job market. However, a family that lives in a poor community will be primarily exposed to inadequate resources and poor education, regardless of their family's individual income status (Aliprantis et al., 2011). The research findings from the Census Bureau were used to help determine where and how poverty has become more concentrated, and how to prevent future generations from being affected.

According to Quillian (2012), the two primary contributors to the high rate of concentrated poverty among African Americans in the United States are economic and racial residential segregation that is experienced in poor neighborhoods. According to Boustan (2013), economic segregation is when access to adequate education, jobs, and public services is concentrated into areas were middle and upper-class residents live and located far away from residents in poor neighborhoods. Racial residential segregation is the separation of a racial group into a confined urban space (Boustan, 2013). The areas in inner-city Chicago that are primarily African American have lost close to 189,000 residents in the past 20 years alone such that areas that were formerly middle-class have become increasingly low-income (Novara, Loury, & Khare, 2017). There is also an issue of segregation within the African American race, often onset by cultural competition, and the likeliness of African Americans leaving the neighborhood once they become successful. Voluntary segregation from other racial groups is also a common factor that makes it difficult to resolve the issue of poverty in minority communities (Quillian, 2012). The primary variance in the upbringing and lifestyles of blacks, whites, and

Hispanics is the economic status of the individuals in their social circle. According to Novara et al. (2017), low-income families in inner-city Chicago reside in neighborhoods where the schools have poor educational resources than schools in neighborhoods with a higher socioeconomic status (SES). A low socioeconomic status results in impaired quality of life, mental illness, and few chances of overcoming their current lifestyle (Boustan, 2013).

Concentrated poverty continues to be a growing problem for African Americans due to racial and residential segregation in poor neighborhoods. In the next section, generational poverty will be discussed.

Generational Poverty

Although the enslavement of African Americans began in 1619, geocoded microdata from 1880-1940 captured the census patterns of African Americans before and throughout the Great Migration to Chicago (Akhtar, 2012). The Great Migration led to African Americans being highly isolated with very little education or occupational opportunities (Logan, 2015). According to Logan (2015), the primary occupation for African Americans was not ranked above servant, maid, cook, or manual labor. There was very little change between 1890-1950 in the occupations and income of African Americans in Chicago and New York.

Racial, residential, and school segregation made it difficult for African Americans to attain a socioeconomic status above poverty (Hunter, 2016). Once school segregation was abolished in 1954, African Americans began the Civil Rights Movement to end racial discrimination and legally gain equal rights (Akhtar, 2012). Once the Civil Rights

Movement ended in 1968, many black families were gradually allowed to participate in fast-track recruitment programs to obtain higher levels of employment. However, the rising levels of unemployment, lack of employment opportunities, and inflation in the preceding decade continued to negatively impact African American families (Akhtar, 2012). There was an increase in income inequality from 1970 to the 1990s along with an increased gap in educational attainment between the wealthy and the poor (Nikulina, 2011).

The income deficit has also led to grandparents raising their grandchildren in parent-absent homes (Kelch-Oliver, 2011). According to Kelch-Oliver (2011), African American grandmothers with a low socioeconomic status assume caregiving responsibilities of their grandchildren at disproportionately higher rates than any other racial or ethnic group. Poverty, mental illness, maltreatment, and substance abuse are primary factors in the dysfunction of the family structure. Children who are raised in grandparent-headed families are at higher risk for serious behavioral and emotional problems, compared to children who are raised by their biological parents (Kelch-Oliver, 2011). The traumatic circumstances that led to grandparents becoming the primary caregiver leads to psychological and emotional consequences for both the grandchildren and the grandparents. By the year 2000, more than 50% of African American children in low-income neighborhoods were living in households headed by a grandparent (Kelch-Oliver, 2011). According to Akhtar (2012), most African American families found themselves in over 300 years of generational poverty by the end of the twentieth century.

Experiencing generational poverty, neighborhood poverty, or neglect during childhood can contribute to poor outcomes later in life (Nikulina, 2011). Nikulina (2011), reported that experiencing generational poverty or neighborhood poverty predisposes children to experience more traumas and they only had few mental health resources to counter these traumatic experiences. To determine if the residents for the Nikulina (2011) study were raised in generational poverty, data from the U.S Census were used based on the descendant's address from 1967 forward. The poverty lineage of the family was determined based on children living in families with maternal and paternal parents, and grandparents receiving welfare assistance. The study determined that childhood poverty made children more susceptible to long-term criminal, academic, and mental health outcomes. Childhood family poverty was a significant predictor of having a lifelong diagnosis of PTSD, crime, and poor academic achievement (Nikulina, 2011). According to Sharkey (2011), raising children in impoverished neighborhoods in one generation may have a substantial negative effect on the family's cognitive ability in the next generation. More than 70% of African American children living in poor neighborhoods will continue to live in poor neighborhoods as an adult (Sharkey, 2011). A parent's childhood neighborhood can continue to have a lingering influence on their children. According to Sharkey (2011), a person's childhood neighborhood can affect their educational attainment as a child, which will influence their employment status and income as an adult. An adult's employment status and income can potentially influence the quality of the home environment their children are raised in, which will ultimately influence the developmental health of that child (Sharkey, 2011).

The Chicago Housing Authority (CHA) conducted a mobility voucher program, and randomly assigned roughly 5,000 families with public housing to different neighborhoods with a higher socioeconomic status. Over 60% of the families who were relocated produced stronger standardized reading and math scores (Sharkey, 2011). Although changing a family's neighborhood brought a radical change in their social environment, the change will likely be a short-term deviation from the familial history of living in a disadvantaged environment (Sharkey, 2011). According to the CHA mobility voucher program, placing families in neighborhoods with higher socioeconomic status can improve the opportunities that are available to adults, their children, and their children's peers (Sharkey, 2011). A neighborhood with a higher socioeconomic status can also improve the parent's mental health by allowing access to adequate resources such as employment, mental health services, and education (Sharkey, 2011). However, it may not undo the lingering influence of the parent's childhood environment (Sharkey, 2011).

Generational poverty is the continued poverty from one generation to the next. One contributing factor is the large number of children who are being raised by grandparents due to absent parents. Absent parents can cause PTSD, and this issue is prevalent in generational poverty.

The Mental Health of Minorities Living in Generational Poverty

Childhood poverty is related to mental health in both childhood and adulthood. Childhood poverty and neglect are reported to play a crucial role in predicting PTSD, chronic depression, academic achievement, and the quality of life for children into

adulthood (Nikulina et al., 2011). Nikulina et al. (2011) analyzed the regression of children and adults who were raised and living in a poor neighborhood. A total of 507 children with a documented history of neglect and 497 children without a history of poverty and neglect were interviewed in adulthood to assess their outcomes. The children who were neglected or grew up in poverty were the most likely to suffer from PTSD once arrested as an adult (Nikulina et al., 2011). Children who were exposed to family poverty while growing up in a poor community were at higher risk for major depressive disorder.

Poverty increases stress in mothers by heightening their exposure to unemployment, poor housing, negative life events, and chronic strains leading to crippling depressive symptoms (Beeber, Perreira, & Schwartz, 2008). The chance for a child living in poverty to grow up healthy depends on the health and mental health of the mother. A mentally healthy mother can provide the behavioral guidance, stimulation, and security a child needs to develop appropriate social, language, and motor skills (Beeber et al., 2008). Ward et al. (2013) conducted a phenomenological study to examine the lived experiences of older African American women with depression. The women stated that they experienced various events and situations from childhood through adulthood that led to their depression. According to a study sample of 272 African American men and women between the ages of 25 to 72, due to experiencing chronic episodes of depression and witnessing generations of family members experience depression (without receiving help), they believed depression was normal (Ward et al., 2013). Besides, African American women were at higher risk for depression but were the least likely to participate in therapy. These coping mechanisms can be a barrier in obtaining

professional mental health treatment, leading to missed opportunities for early diagnosis. Adverse childhood experiences (ACEs) are important factors that negatively affect an individual's life course and are associated with a broad range of psychiatric health outcomes (Evans & Kim, 2013). ACE's are reported to influence how individuals cope with stressful situations. These coping mechanisms can be used to either prolong or ameliorate the individual's stress response (Nusslock & Miller, 2016). For example, a stress response can be terminated by engaging in strategies that are aimed at resolving the stressor. However, little attempt at resolving the stressor and focusing more on modulating the affective response could result in an unresolved stressor (Wadsworth, 2015). Evans and Kim, (2013), reported that children living in a family environment that is stressful are likely to have strategies that are avoidant focused and are less likely to engage themselves in strategies that aim at solving the problem. Therefore, such individuals present with more stressors compared to those who are not previously exposed to ACEs. Besides, they develop fewer strategies that are effective in coping with the stressors in their adult life.

A family's cognitive ability is reduced by more than half when exposed to two or more consecutive generations of poverty (Sharkey, 2011). Sharkey (2011) determined during a cognitive study on Chicago youth that the influence of disadvantaged neighborhoods lingers in children, even if they move to a more diverse neighborhood. If the child's caregiver was raised in a similar disadvantaged environment, the parent's childhood environment can influence the next generation (Sharkey, 2011). Poor cognitive and socio-emotional abilities are associated with low emotional regulation of adults in

low-income neighborhoods (Mondi, 2017). According to Mondi (2017), social problems in childhood are associated with a lower socioeconomic status in adulthood. The poor neighborhood a person originates from determines their educational attainment, which influences their occupational status and income as an adult. Occupational status and income influence the quality of the home environment in which a person raises their children also influence the mental health trajectory of the child (Sharkey, 2011). Based on observational studies and numerous residential mobility programs, this pattern is likely to cause a cognitive deficit that extends across generations (Sharkey, 2011). Therefore, children who were exposed to generational poverty are at a higher risk for chronic mental health illnesses.

In addition to patterns of cognitive deficiencies extending across generations, mental illness has the capability of extending across generations as well. According to the family stress theory, African American youth in low-income communities were more likely to report mental health problems, substance abuse, and criminal involvement if there was an adult in the home with a history of mental illness, substance abuse, or incarceration (Voisin, Elsaesser, Kim, Patel, & Cantara, 2016). Family stressors lead to disruptions in the home that impair the adult's response to the developmental and emotional needs of their children (Voisin et al., 2016). Economic stress experienced by parents also reduces supportiveness, child monitoring, and the ability to maintain employment (Lukyanova, Balcazar, Oberoi, & Suarez-Balcazar, 2014; Voisin et al., 2016). African Americans with mental illness are underserved in independent rehabilitation and vocational mental health services making them more likely to

experience economic, social, and vocational disadvantages than Whites (Lukyanova et al., 2014).

To assist with the shortage of mental health services for low-income minorities, the Crisis Intervention Team (CIT) in Chicago was assembled to connect people to mental health treatment and other resources to reduce arrests and increase the use of emergency psychiatric resources during police response (Watson & Wood, 2017). According to Watson (2017), during 428 mental health-related police calls hospital transports were utilized more often than arrests. Ensuring Chicago police have direct access to mental health resources has helped to divert African Americans from the criminal justice system at the initial point of police contact, while also addressing mental health disturbances in a manner that is less stigmatizing than emergency mental health facilities (Watson et al., 2017). However, community mental health services in Chicago have consistently decreased (Watson et al., 2017). In 2016, Chicago went from having 12 mental health facilities to only having five, with several of the closed facilities being located in low-income African American neighborhoods (Quinn, 2018). The remaining five mental health facilities attempt to provide culturally sensitive mental health treatment to the African American and Latino community for free. However, most of the African Americans and Latinos who dare to seek professional mental health treatment are often turned away or waitlisted because the clinics are understaffed (Quinn, 2018).

The decrease in the quality of the home environment among minorities living in generational poverty, along with an increase in family dysfunction was associated with higher depressive symptomology in low-income African Americans from urban Chicago

(Mondi, 2017). Depression is the most common mental illness and affects more than 12 million minority women and more than 6 million minority men. Depression evolves or time as a person interacts with their environment and deviates from normal patterns of development (Mondi, 2017). The disabilities associated with depression include cognition impairment, inadequate self-care, and lack of productivity (Ward et al., 2013). It is important to study how a person's early life experiences and risk factors interact to position individuals on a path towards developing depression (Cicchetti & Natsuaki, 2014). A lack of motivation, sadness, along emotional and behavioral deficiencies are identified as being risk factors for African Americans living with depression (Sohail, Bailey & Richie, 2014).

Parental or guardian stress is likely to affect the mental health of the child. Besides, a family's cognitive ability is reduced by more than half of the family remains in poverty for more than two generations while low socioeconomic issues as a child lead to continued issues as an adult and this cycle progresses due to minorities' reluctance to seek mental health treatment.

Reluctance to Seek Mental Health Treatment Among Minorities Living in Generational Poverty

Studies have shown that African Americans are reluctant to seek professional mental health treatment, regardless of their gender or age (Ward, 2013). The reluctance for African Americans to seek professional mental health treatment affects well-being, health, and optimal functioning (Eshun & Packer, 2016). Untreated mental illness is also associated with increased mortality, loss of earning potential, and decreased quality of

life (hays, 2015). A long history of discrimination, racism, and prejudice has influenced how African Americans perceive themselves and others while also influencing how others perceive them (Eshun et al., 2016). African Americans have a distrust of Whites and most Western worldviews, making them hesitant to consult or interact with outside races in fear of being exploited. According to Eshun & Packer (2016), African Americans report worse levels of life satisfaction psychological well-being than Whites. Past and present experiences with prejudice, discrimination, and racism influence negative attitudes toward socially constructed institutions such as healthcare, reducing the likelihood of reporting mental illness or seeking professional help (Eshun et al., 2016). The fear of being treated unfairly can promote feelings of poor self-worth, learned helplessness, and ultimately poor psychological health. Socioeconomic factors such as higher unemployment rates and lack of access to quality mental health care are also significant issues that contribute to additional risk for African Americans (Eshun et al., 2016).

African American mothers living in poverty are reluctant to obtain mental health treatment because they view professional help as being too difficult to address until the consequences to the child are considered. The behavior of infants and toddlers can be negatively affected with as little as six months of exposure to maternal depression (Beeber et al., 2008). According to Griffith, Brinkley-Rubenstein, Thorpe, and Metzl (2015), African American men may use the same ideology to define their mental health as they use to define their manhood. Independence and self-reliance are viewed as the most important approach to addressing health issues. Health is considered a low priority

until it impairs an aspect of their lives such as employment, sexual relationships, providing for a family (Griffith et al., 2015). The results of a qualitative phenomenological data analysis indicated that African American women 60 and older believe factors such as poverty, trauma, and disempowerment can cause depression (Ward et al., 2013). The data analysis also indicated that African American women viewed depression as a normal reaction to life circumstances and did not see the need of seeking professional treatment. The culturally-based coping mechanisms create a barrier to seeking professional mental health treatment, potentially resulting in missed opportunities for early diagnosis and treatment for mental illness (Eshun et al., 2016).

African Americans account for only 12% of the population but make up 18.7% of those affected by mental illness (Ward, 2013). According to the Illness Perception Questionnaire-Revised (IPQ-R) that was administered to 180 African American men and women, one of the leading causes of minorities being reluctant to seek mental health treatment is mistrust (Ward, 2013). Although progress has been made over the years, historical and contemporary racism has led to a mistrust of authorities and has left minorities to feel mental health professionals will not have their best interest in mind (Ward, 2013). Many African Americans prefer to use the church as a coping mechanism for mental and emotional problems instead of seeking professional mental health treatment (Hays, 2015). Black churches are considered to be trusted institutions and are considered to be a protective factor for mental health in the African American community (Hays, 2015). According to Hays (2015), African Americans have primarily been taught to cope and seek help from God instead of seeking professional mental health treatment.

African Americans rely on prayer, reading the bible, religious music, and attending church services. In some cases, professional mental health treatment can be viewed by church members as a lack of faith in God (Hays, 2015). The first Black Church was established in the United States in 1750 and evolved through the span of slavery, emancipation, and the Civil Rights Movement. As the black church evolved through adversity, it became an agent of empowerment, social change, and trusted help in the African American community (Hays, 2015). Initially, the church was the only safe place African Americans could go to voice their anger, sadness, and fears about living in a racially oppressive society. African Americans are the most religious racial group with approximately 80% of African American Christians belonging to one of the seven denominations in the black church. The leadership and guidance that African Americans receive from Black churches are often administered by other African Americans from their community. Less than 2% of the American Psychological Association's (APA) members are Latino or African American. The lack of minority mental health practitioners can make minorities feel like they are being judged and worry the mental health professionals will not be culturally competent enough to treat their specific issues (APA, 2014).

Mental illness is considered a risk factor and a common prerequisite for the overrepresentation of African Americans in jails and prisons (Hawthorne et al., 2012; Youman, Drapalski, Bagley, & Tangley, 2010). African Americans tend to suffer from more symptoms of mental illness than non-Hispanics and Whites upon being incarcerated. Poverty, racial bias in the access to treatment, and racial biases of the

deciding party that determines if the behavior resulting from mental illness deserves treatment or punishment are leading barriers for obtaining professional mental health treatment (Youman et al., 2010). Effective mental health treatment requires a mental health provider that is sensitive to the culturally unique needs of African Americans. According to Hawthorne (2012), incarcerated individuals have access to clinicians and correctional staff. Although Whites were more likely to obtained mental health treatment before incarceration, there were no differences in treatment-seeking between African Americans and Whites while being incarcerated (Youman et al., 2010).

The reluctance of the minority population to seek mental health treatment has led to several generations of minority families that have not sought mental health treatment for the ongoing effects of living in poverty in inner-city Chicago. Untreated depression disrupts the family dynamic by causing depression symptoms in children of mothers who have a depression or substance abuse disorder (Sohail et al., 2014). According to Sohail, Bailey, and Richie (2014), the slavery lineage of African Americans has led to distinctive traditions for addressing mental health. African Americans tend to feel guilty when they pursue activities that promote their mental health or self-development. This indifference causes a conflict in family survival and personal development, leading to an ongoing cycle of depression in poor African American communities (Sohail et al., 2014).

Outcomes for Lack of Mental Health Treatment and Generational Poverty

Although neighborhood poverty and generational poverty each contribute to poor outcomes later in life, both circumstances experienced concurrently lead to a higher risk for mental illness, poor academic achievement, and crime. Nikulina (2011) found the

most common form of child mistreatment is neglect, and child neglect has a positive relationship to poverty. Of the 59% of child maltreatment cases reported in the United stated, 50% of those cases result from neglect in poor neighborhoods. Neglected children also score lower on IQ tests as adults and are twice as likely to exhibit symptoms of mental illness and personality disorder. Childhood neglect is also a strong predictor of the life outcome as an adult. They are more likely to experience language and reading delays, suffer from depression, and are more likely to drop out of school as a result of excessive absences and delinquent behavior (Nikulina et al., 2011). Children who are raised in poverty often have mental health disparities that remain untreated in adulthood.

African American youth in low-income neighborhoods are exposed to higher rates of violence and homicide and are 20% more likely to report having serious depressive or PTSD symptoms compared to Whites (Watson et al., 2017). African Americans have more severe, disabling, and persistent depressive episodes compared to Whites, and are most likely to enter primary care with more depressive episodes than any other racial group (Hays, 2017). According to Hays (2017), African Americans living in poverty are not necessarily at greater risk for psychiatric disorders than other racial groups, they are disproportionately exposed to economic deprivation that leads to more instances of psychological distress.

There is an over-representation of African Americans in the criminal justice system at every level of the judicial system, from initial contact to sentencing and incarceration (Voisin et al., 2016). Homicide is the second leading cause of death in Chicago for African American youth between the ages of 10-24. In the United States,

14.5% of incarcerated men and 31% of incarcerated women suffer from a serious mental illness (Voisin et al., 2016). African American juveniles represent 35% of the detained population, but only represent 13% of the overall youth population (Voisin et al., 2016).

Mental health disparities among African American women in poor neighborhoods can lead to impairments in parenting, mental health, and place them at a higher risk for domestic abuse (Gilroy et al., 2015). Domestic violence is considered to be a circumstance that primarily affects women. The detrimental effects of domestic violence have been proven to cause depression, psychological distress, and chronic illness in the parents and children who are involved in a domestically violent environment. Partner abuse for families in poor neighborhoods often leads to a household with an emotionally absentee father (Gilroy, 2015). Women who are in abusive relationships are prone to tolerate the relationship for a longer period if they are currently living in poverty. The article also discusses how the behaviors of the parental figure can have lifelong effects on the family dynamic, leading to emotional and social impairment in the children who witness the abuse. Financial struggles, along with a lack of sustainable employment place women at higher risk for abuse.

To determine how women living in poverty experience poor mental health coincide, a sample of 300 women who are currently living in abuse shelters were interviewed (Gilroy, 2015). The women were currently living below the poverty line and did not have a steady source of income. There was a direct link between the severity of abuse and income level, and how it impacted the woman's mental health. Women who experienced severe abuse and were living within the poverty guidelines were at higher

risk for mental health problems, perpetuating the cycle of poverty and mental illness. Overall, poverty is considered to have an impact on mental health based on the severity and type of abuse.

Theoretical Considerations

If African Americans utilize professional mental health services, future generations can benefit from a home environment where the mental health of the parental figure is being addressed, potentially leading to more stable home life. If experiencing poor mental health is associated with the inability to retain employment, substance abuse, and depression, strengthening the mental health state of African American families living in generational poverty can address re-occurring issues in the home and the community. The personal views and concerns of African Americans living in generational poverty will be explored using interviews and open-ended questions. Obtaining personal viewpoints and experiences will allow the lack of mental health treatment among African Americans in poor neighborhoods to be viewed from different perspectives.

Many programs address the impact of experiencing generational poverty in inner-city Chicago (i.e. additional policing, welfare-to-work, public assistance) but very few address the underlying cause. To promote change within an environment, it is important to engage with the group being studied. Personal engagement leads to a better understanding of a group's opinions, situations, and insights instead of just predicting their behavior (Erickson, 2011). The researcher will use interviews to explore the attitudes and lived experiences of African Americans living in inner-city Chicago experiencing generational poverty and are reluctant to seek mental health treatment.

In the next chapter, the researcher's focus was on the qualitative phenomenological research method which was utilized in the study. The methodology included detailed information on how the study was conducted, an explanation for the study's design, and the data collection and analysis techniques. Besides, other subsections presented were the research design and rationale, procedures for recruitment of participants, and data collection, and analysis.

Mistrust

African Americans tend to have a mistrust of the healthcare system that derives from historical events that led to the reluctance to engage in health trials and mental health treatment. The Tuskegee syphilis study is one of the most recognized research studies that conducted clinical trials on African Americans by utilizing mistreatment and deception for the entire duration of the study (Scharff et al., 2010). According to Scharff et al. (2010), there is a history of medical experimentation and abuse among African Americans in research studies that extends more than four centuries. The lack of cultural diversity and competency among mental health professionals is also considered to be a major contributor to African Americans mistrust of the medical research and health care infrastructure (Scharff et al., 2010). The mistrust of clinical and health professionals is also influenced by negative encounters with health care providers. There has been ample documentation regarding discriminatory and racist practices among individual clinicians (Wendt, Gone, & Nagata, 2014). There have been over 132 peer-reviewed journals that have exhibited racism in their delivery of mental health treatment (Wendt et al., 2014). African Americans were overly diagnosed and provided less intensive and lower quality

interventions (Wendt et al., 2014). The multicultural counseling and psychotherapy (MCP) movement uncovered frequent documented cases of misdiagnoses, primarily overly diagnosing African Americans with schizophrenia and other psychotic disorders (Wendt et al., 2014) According to the MCP movement, culturally insensitive or oppressive therapy can potentially do a patient more harm than if they never tried to participate in therapy (Wendt, Gone, &Nagata, 2014). Based on the APA's multicultural guidelines, traditional Eurocentric interventions, and therapy models that are used to train most therapists may be harmful or ineffective to culturally diverse individuals (Wendt et al., 2014). Ethnic minorities receive less empathy, information, and attention than their White counterparts (Scharff et al., 2010). African Americans are also less likely to receive medical services than White patients who complain about similar symptoms (Scharff et al., 2010). The most effective approach to encouraging mental health treatment among racial, ethnic, and cultural minority clients may be to match clients and clinicians using linguistic and racial commonalities (Wendt et al., 2014).

The Common Sense Model

The common sense model (CSM) is a theory that suggests that people have common-sense beliefs about illnesses based on personal experience, formal education, cultural traditions, and stories from family and friends (Ward & Heidrich, 2009). The beliefs determine how individuals cope with health threats and represent the cause, consequences, identity, timeline, and control of the health threat while influencing the coping responses. Research that has focused on African Americas and mental illness found a long history of negative attitudes toward mental illness and stigma associated

with seeking professional mental health services (Ward & Heidrich, 2009). According to Ward & Heidrich (2009), a public opinion poll determined that 63% of African Americans viewed mental illness as a personal weakness and associated mental illness with shame and embarrassment.

The CSM proposed seven key components that represent beliefs about mental illness: *identity, cause, timeline, consequences, control, illness coherence, and emotional representation*. Identity refers to the beliefs about the symptoms that are associated with the illness. Cause pertains to the beliefs about the factors that can lead to mental illness. Timeline focuses on the individual's beliefs about whether the illness is cyclic or persistent. Consequence focuses on beliefs about short and long terms outcomes for mental illness. Control includes information about how curable and controllable mental illness is perceived as being. Illness Coherence focuses on the individual's belief of how well they understand the mental illness while emotional representation refers to the personal emotional response to mental illness.

A study by Ward & Heidrich, (2009), investigated African American women's beliefs about mental illness by using the Illness Perception Questionnaire-Revised (IPQ-R), developed based on the CSM. A total of 246 African American women were recruited with 199 of the women completing the questionnaire, and 13 questionnaires were not considered due to missing information. The study utilized a 5-point Likert Scale to measure the participant's responses. Based on the study findings, some African American women believed they were not susceptible to depression and believed depression was due to having a weak mind, troubled spirit, poor health, and a lack of self-love Others tended

to perceive psychological distress as part of their role as a "strong Black woman" and will cope with mental illness through endurance instead of seeking treatment. The results also revealed that the women strongly agreed with using religion to cope with mental illness and would probably use informal support networks as an alternative. The perceived stigma of mental illness was significantly related to coping and beliefs about mental illness. When the stigma of seeking professional mental health treatment was low, and participants were more likely to utilize mental health services and less likely to use avoidance coping. There were no significant age differences for the perceived stigma of mental illness. This study provided a snapshot of the perceptions and preferred coping mechanisms of African American women of various ages while lightly addressing the cyclic perception of mental illness. However, there is a need for further research regarding the experiences and attitudes of the African American community.

Perception of Poverty

Social psychologists have examined attitudes towards the poor based on the consequential role outlook plays on the perception of poverty, impact on public policies such as welfare (Giddens, 2013; Piston, 2018). The primary circumstances that contribute to poverty tend to vary for urban neighborhoods in the United States (Tagler & Cozzarelli, 2013). To establish a social theory for the social problems that continue to affect future generations, the contributing factors that led to entire communities being impoverished must be addressed (Hanna & Karlan, 2017). Most of the research that has been completed to date has primarily focused on the attributes that are perceived to cause poverty (Bucca, 2016; Gugushvili, 2016). Upper-middle-class Americans believe poverty

is caused by individual factors such as laziness, substance abuse, and low intelligence (Tagler et al., 2013). Individual causes are endorsed more than structural causes such as poor educational system, discrimination, and a lack of sustainable employment (Kao, Chen, Wu, & Yang, 2016).

According to a study by Tagler & Cozzarelli (2013), there was a drastic variance between poverty caused by individual and structural factors when examining the consequences of a person's attitude towards the poor. In this study, Americans were showed to have had a more favorable attitude towards structural attributes, such as welfare, they were supportive of public policies that supported free healthcare for welfare recipients. However, there was minimal support for individual factors such as criminal convictions while a vast majority also favored policies that rendered convicts ineligible to receive employment or any type of public assistance. There are currently more than 46 million Americans living below the poverty line (Proctor, Semega, & Kollar, 2016). Social theories are researching how the perception of the poor not only influences that help that is provided, it affects how Americans assist the poor as well.

Summary

If African Americans utilize professional mental health services, future generations can benefit from a home environment where the mental health of the parental figure is being addressed, potentially leading to home life is more stable. If experiencing poor mental health is associated with the inability to retain employment, substance abuse, and depression, strengthening the mental health state of African American families living in generational poverty can address re-occurring issues in the home and the community.

The personal views and concerns of African Americans living in generational poverty will be explored using interviews and open-ended questions. Obtaining personal viewpoints and experiences will allow the lack of mental health treatment among African Americans in poor neighborhoods to be viewed from different perspectives.

Many programs address the impact of experiencing generational poverty in inner-city Chicago (i.e. additional policing, welfare-to-work, public assistance) but very few address the underlying cause. To promote change within an environment, it is important to engage with the group being studied. Personal engagement leads to a better understanding of a group's opinions, situations, and insights instead of just predicting their behavior (Erickson, 2011). The researcher will use interviews to explore the attitudes and lived experiences of African Americans living in inner-city Chicago experiencing generational poverty and are reluctant to seek mental health treatment.

In the next chapter, the researcher will focus on the qualitative phenomenological research method that will be utilized in the study. This methodology will include detailed information on how the study will be conducted, an explanation for the study's design, and the measurements for the study. The topics include the research design and rationale, methodology, procedures for recruitment, participant, and data collection, sample size, and population, and interviews.

Chapter 3: Methodology

The purpose of this research study was to explore the lived experiences and attitudes of minorities who are living in generational poverty and have a reluctant attitude towards mental health treatment A phenomenological qualitative methodology study was used to research the lived experiences that contribute to the attitudes toward mental health treatment among minorities who are living in generational poverty in inner-city Chicago.

In this chapter, the research design and rationale are outlined, the methodology including the explanation for choosing a qualitative design, procedures for recruitment, participation, and data collection. Additionally, the method for sampling, population, field testing, interviews, the measurement approach, data analysis, ethical considerations, and issues of trustworthiness are presented.

Research Design & Rationale

Addressing the lack of professional mental health treatment among African Americans living in generational poverty will promote social change by obtaining firsthand information on the lived experiences of African Americans living in inner-city Chicago experiencing generational poverty and are reluctant to seek mental health treatment if it is ever needed. Exploring the lived experiences that contribute to the attitudes toward mental health treatment among minorities living in generational poverty can potentially provide the reasons for not seeking mental health treatment and could alleviate the symptoms associated with poor mental health such as psychological distress, severe depressive episodes, poverty, and violence. Reduction in mental health care

disparities can restore African Americans trust in clinicians and encourage African Americans to seek professional mental health treatment when needed. If adults living in generational poverty are willing to seek treatment, they can encourage their children and other family members to obtain treatment as well. There have been several programs implemented in inner-city Chicago to assist with the outcomes of living in generational poverty (i.e. lack of employment, substance abuse, crime; Rankin & Quane, 2000). Such programs include economic security programs such as housing subsidies, tax credits for working families, and food aid. All these reforms are intended to seemingly respond to urban poverty. However, if these reforms are not successful in addressing the familial lineage of generational poverty and the lived experiences that contribute to the reluctant attitudes, they will continue to suffer and this will affect their mental health status and productivity (Owens & Clampet-Lundquist, 2017).

The design of this qualitative study was chosen to answer the research question:

Research Question 1–Qualitative: What lived experiences contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago?

Methodology

Qualitative research is one of the most flexible research methods and it encompasses various methods and structures (Creswell et al, 2007). It can be defined as a systematic scientific inquiry that is in most cases a narrative and seeks to inform the researcher's understanding of a specific phenomenon under study (Astalin, 2013). In qualitative research, the collected data is organized into categories and themes from

which similar patterns can be identified (Creswell et al, 2007). Data is gathered by the use of open-ended questions and the responses are in the form of direct quotations. In this methodology, interviews are an integral part of the research (Astalin, 2013). In qualitative methodology, there are four known qualitative research designs: phenomenology, ethnography, grounded theory, and case study (Merriam & Tisdell, 2015).

Ethnography focuses on studying the origin and social relationships within society (Creswell et al, 2007). It concentrates on studying people's cultures and ways of living over a long period. The researcher conducts fieldwork and gets involved with the participants through ongoing interactions at home or in society and this takes place over a long period (Astalin, 2013). The common factors are that the study participants have something in commons such as religion, tribe, a shared experience, a lifestyle, or geographical regions. This involves the use of data collection techniques such as interviews which may be both formal and informal (Merriam & Tisdell, 2015). Besides, participant observations are used and therefore this design is time-consuming as the researcher spends a lot of time in the field with the study participants (Creswell et al, 2007). Therefore, ethnography design was not suitable for this study as I was not studying the origin or social relationships but rather a phenomenon.

Grounded theory design was developed by Glaser and Strauss (1967). These researchers suggested the use of systematic methodologies in gathering data to develop theories based on the research ground on the collected data (Creswell et al, 2007). This design allows for the emergence of theories for the collected data. The process followed is systematic yet flexible and involved data collection, data coding, and finally making

connections from the data to see theories generated from the data (Astalin, 2013). Therefore, in this design, the researchers engage in the research with an open mind and do not have a pre-determined theory mind since theory formulation is from the data obtained which allows the researcher to provide explanations on how people experience and provide responses to certain events (Astalin, 2013). The main feature of this design is the development of new theory from the collected and analyzed data (Creswell et al, 2007). The explanations provided are new knowledge that develops new theories about a specific phenomenon. Therefore, this study design was not suitable for this study as I was not seeking to develop any theories.

Case study designs can be defined as the analysis of events, persons, projects, policies among other systems studies holistically using one or more methods (Merriam & Tisdell, 2015). Case studies have a wide application in both life and social sciences and therefore they may be descriptive or explanatory (Astalin, 2013). Besides, they can also be qualitative or quantitative describing a single entity or single unit. This design helps to explore causation to find underlying principles. They can either be retrospective whereby there is an established criterion for selecting the cases based on historical records or prospective whereby established criteria help to identify cases fitting the criteria and are included as they are made available (Merriam & Tisdell, 2015). There are three types of cases; key, outliers, and local knowledge cases. The case study design did not fit the research study since no single entity was under investigation.

Phenomenology design can be described as the study of phenomena such as situations, events, experiences, or even concepts (Astalin, 2013). The world is surrounded

by phenomena that we do not fully understand. This happens because at times because the phenomena have not been fully described or explained (Merriam & Tisdell, 2015). In other instances, our understanding of the phenomenon may be unclear (Creswell et al, 2007). Therefore, phenomenological research can be used whenever a gap exists in our understanding and requires clarification and this is achieved through a systematic manner. Phenomenological research does not necessarily provide explanations for the phenomenon but provides insights as well as raises awareness about the phenomena specifically from those experiencing the phenomenon (Creswell et al, 2007). This study design was the most suitable design for the research.

Therefore, since the current study required a deep understanding of a phenomenon which is generational poverty and mental health, a phenomenological qualitative research method was the most suitable qualitative study design for the research study. The qualitative research design involved collecting data using in-depth interviews, focus groups, or field observations to understand the problem from the informant's perspective (Creswell, 2014). Data that is collected and analyzed in this way provides a deeper understanding of how people perceive their current circumstances, and how they interact with their social environment. It is important to select participants who are currently experiencing the problem being studied so the targeted population can be accurately represented. One of the key components of a phenomenological study is interaction with the group being researched. The primary goal in phenomenological research is to describe the lived experiences of the participants instead of relying on measurements or preconceived ideas about the phenomena (Astalin, 2013). Quantitative methodologies

such as experimental designs focus more on testing the hypothesis and statistical data and do not take place in the participant's natural setting (Erickson, 2011). The phenomenological methodology is also less structured, allowing more opportunity for open-ended questions. This methodology approach encourages the participant to share particular details about their experience. Other methodologies such as a quasi-experimental research method are more structured and do not allow the participant to freely share personal information. A quasi-experimental design limits the information in the research to the particular variables being studied (Erickson, 2011). The way a person behaves is based on what they find meaningful. This approach allows capturing the community's point of view regarding their experiences, community, and current circumstances. This research analysis was used to address the lived experiences that contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago.

Procedures for Recruitment, Participant, and Data Collection

This research study utilized purposeful sampling to recruit study participants. The inclusion criteria for this study required participants to be of African American descent, between 18-65 years of age, have at least 3 generations of family that has lived in poverty in inner-city Chicago. Generational poverty was defined as currently living at or below the poverty level, and coming from a lineage of generational poverty. To define the poverty level, the federal poverty guidelines were used to define poverty for this study. The federal poverty level for Illinois is $0-$25,750 annually for a family of four. An additional $4,420 was added annually for every additional dependent residing in the

participant's home. Income was determined based on the voluntary admission of the candidate. As previously mentioned, purposeful sampling was used to recruit participants as this is a very sensitive topic of study where the majority of the potential participants may decline to participate in the study if quota sampling were to be used. The researcher recruited participants through advertisements placed on public social media platforms such as Facebook and Twitter. Advertisements were also be placed on Facebook social media groups that contain minorities who live in Chicago. Recruitment posters were placed at public bus terminals and advertisement billboards in inner-city Chicago. The bus terminals and billboards were chosen due to the heavy traffic of both locations that consist of the targeted population for this research. The advertisements remained posted until the needed number of participants was obtained. Participants showing interest in taking part in the study received a request to participate in the study via email which was also comprised of some screening questions (Appendix A) to ensure that they met the selection criteria for the study. Participants who met the minimum criteria were invited to participate in the study. The demographic questionnaire pre-screened the participants by collecting information regarding their familial lineage, ethnicity, socioeconomic status, and reluctance to seek professional mental health treatment. In-depth interviews with open-ended questions were administered to recruit participants who are residents of inner-city Chicago, who are living in generational poverty and have a reluctant attitude towards mental health treatment. Their personal experiences with mental health concerns were also explored. Some of the interview questions consist of the following (Appendix C):

1. How would you describe the common challenges you experience while living in poverty in inner-city Chicago?
2. In your opinion, what role do you think generational poverty played in your family's mental health?
3. What is your attitude towards mental health treatment?
4. In your opinion, what do you think caused your attitude towards mental health?

The interviews allowed the researcher to explore participants' attitudes and lived experiences towards seeking mental health treatment. The open-ended questions explored experiences from the participant's perspective of growing up in generational poverty as one of the factors that have shaped their attitude of seeking professional mental health treatment. The information obtained during the research study has been stored in lockable cabinets for 5 years after which it will be disposed of by deletion or shredding.

Sampling and Population

For this study, the researcher used purposive sampling and snowballing to select 10 African American men and women living in generational poverty in inner-city Chicago. Welman and Kruger (1999), highlighted that purposive sampling is considered the most important non-probability sampling method for the identification of study participants in a phenomenological study. The researcher selected the sample size based on their judgment and availability of the participants considering their work and life schedule. Snowballing sampling was also used to expand the sample size to meet data saturation. The identified participants or informants were requested to recommend others who meet the inclusion criteria to participate in the study. O'Reilly and Parker (2013)

define data saturation as the point at which no new information is gathered during data collection even as the sample size is increased. According to Fusch & Ness, (2015), a sample of six to 30 is sufficient for data saturation to occur. Creswell (2015) recommends interviews with up to 10 people for a phenomenological study. Therefore, a total of 10-15 study participants formed the final sample size and was dependent on data saturation and the availability of study participants. Participants were recruited based on their willingness to volunteer and were chosen based on a first come first serve basis until the participant quota had been met. All the participants grew up in inner-city Chicago and are from a family lineage of poverty that extends at least three generations. All candidates were asked to complete a questionnaire that lists the criteria that must be met to participate in the study. The questionnaire asked questions to confirm the candidate has at least three generations of the family lineage of poverty in inner-city Chicago. The researcher also pre-screened potential participants to ensure the basic criteria for the research study were met. The poverty line was also determined by the receipt of welfare assistance. Candidates self-certified all information about the criteria for this study.

Field Testing

The interview protocol included field-testing, using African Americans who have experienced generational poverty in inner-city Chicago to discuss their attitude towards seeking mental health treatment. A field test study was conducted to test the interview protocol and to determine the approximate length of time to conduct interviews with each participant. The field test was also used to test the strategy for recruiting participants, research tools, and research protocols. Field studies help identify potential problem areas

with the research protocol and data instruments before the full study being implemented (Hassan, Schattner, & Mazza, 2006). Potential issues with the interview questions can also be highlighted during the field testing with the respondents who meet the inclusion criteria (Hassan et al., 2006). The field study ensured that the respondents understand the terminologies used in the interviews.

Interviews

The identified participants received the recruitment letter elaborating on all the details about the study. Participants who responded to the recruitment letter (Appendix A) were pre-screened for interviews by using the demographic questionnaire (Appendix B). The recruitment letters were handed out to random facilities located at bus terminals, welfare facilities, and healthcare facilities in the inner-city of Chicago. Before the interviews begin, the participants were first presented with the consent forms which they were required to carefully read and understand, sign, and return to the researcher. Due to COVID-19 social distancing mandates, face-to-face interviews were not conducted. All interviews were conducted utilizing audio communication. All the participants chose a neutral location that was comfortable and quiet without disruptions. The researcher asked the participants questions from the interview questionnaire that lasted approximately 1-2 hours (Appendix C) and all interviews were audio-recorded. All 14 interview questions corresponded to the research questions for the study. The interview questions allowed the participants to address the experiences in detail for the familial generations that have lived in poverty in inner-city Chicago. The interview questions also allowed the

participant to provide details on the attitudes towards mental health treatment of the family that has lived in poverty in inner-city Chicago.

Table 1

Alignment Between Research Questions and Interview Questions

Research question	Interview question
RQ1: What lived experiences contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago??	Question 1 Question 2 Question 3 Question 4 Question 5 Question 6 Question 7 Question 8-14

The participants were allowed to check their interview responses in case of any misinterpretations, clarifications, or missing information. Member checking validated the research results and improved their credibility. Once the interviews were complete, participants were allowed to ask questions and review the research findings after the study was completed. If any participant requested information on mental health, a referral list of professionals was provided.

Measurement Approach

The interview protocol was developed by the researcher in line with the research questions and review of existing literature. Validation of the interview protocol was analyzed by a group of experts and a field test. The interview protocol was chosen using a phenomenological approach to obtain a deep understanding of the lived experiences of each participant. The protocol was developed based on existing literature (Ward et al., (2013) that implemented a phenomenological approach to examine the lived experiences

of African American women living with depression. The researcher used open-ended questions to conduct in-depth interviews with African Americans in inner-city Chicago to explore the lived experiences that contribute to the attitudes toward mental health treatment. The optional setting for interviewing all participants was video communication but was not utilized. The researcher made participants aware of the terms of use for the provided information and informed them of the purpose of this study. The participant's consent was verified by signing the authorization forms to conduct and record the interview and included an option for the participant to verbally opt-out of the interview at any time. The consent form informed the participants that all of the information obtained in the study will remain confidential, and all interactions will adhere to the ethical guidelines created by the American Psychological Association (APA, 2014). The participants were also instructed to avoid disclosing any identifiable information that could compromise the confidentiality of the study. Further, they were requested to choose a pseudonym for use in identifying them during the study.

Theories Guiding Data Analysis

Data for this study were analyzed using thematic analysis. Thematic analysis is a six-step structured system that assists the researcher with mapping the primary themes in the data (Braun & Clarke, 2006). The six steps to thematic analysis include becoming familiar with the research data, assigning codes to the data to sufficiently describe the content, searching for patterns or themes within the codes for all interviews, reviewing themes, defining themes, and producing a final report (Braun & Clarke, 2006).

The framework method is a flexible and systematic approach used in analyzing qualitative data. It is also referred to as thematic analysis or qualitative content analysis and it identifies any commonalities and differences in qualitative data obtained for example in the case of this study from the interview responses, before considering any other relationships in the data. Framework analysis allows for the drawing of explanatory or descriptive conclusions that are clustered around the identified themes. This study was qualitative and produced detailed information from the interviews. From the data, several themes and patterns were identified and an in-depth analysis of these themes allowed the views of each research participant to be connected to the conceptual framework aspects so as not to lose the context of the participants' views. This study's conceptual framework was based on social stratification and racial segregation theories which are theories focusing on the poverty cycle in poor neighborhoods and they also connect to mental health because lower socioeconomic status is highly correlated with mental illness and reluctance to seek mental health treatment. The attribution theory conceptualizes mental illness as stigma and lack of access to treatment. Therefore, the identification of themes and patterns emerging from the data provided the direction to follow to produce highly structured themes and patterns from the data.

Thematic analysis was a six-step structured system that assisted the researcher in mapping the primary themes in the data (Braun & Clarke, 2006). The six steps in the thematic analysis include becoming familiar with the research data, assigning codes to the data to sufficiently describe the content, searching for patterns or themes within the codes for all interviews, reviewing themes, defining themes, and producing a final report

(Braun & Clarke, 2006). In this study, the framework method was used for thematic analysis of the semi-structured interview transcripts which were the focus of this study. Themes were developed through a systematic search for patterns and generation of full descriptions that are connected to the framework to shed light on the phenomenon being investigated. This simply means making systematic comparisons across all responses and refining each theme.

Data obtained from the interviews using open-ended questions were recorded in notebooks as well as audio recorded with permission from the participants. Further, the recorded audio files were transcribed using audio to text automatic transcription service, to convert the audio files into text for thematic coding. Inductive coding was adopted for this study, whereby codes were created from the qualitative data arising from the participant's responses. When creating the codes, labels were assigned to words or phrases to represent important or recurring themes for the responses. Theories were used to inform the coding and analysis process. Therefore, data coding began by first assigning all the responses from the interviews into categories and themes. After coding, themes were generated by first looking over the created codes, identifying patterns within the codes, and developing the themes. Themes are broader than the codes, hence several codes are likely to be combined into one theme. Codes that were not relevant or were vague were discarded since the developed themes revealed important data that fulfills the study purpose. In qualitative research, the collected data is organized into categories and themes from which similar patterns can be identified (Creswell et al, 2007). Data was gathered by the use of open-ended questions and the responses obtained were in the form

of direct quotations. Further extraction of meanings was done from the categories. The meanings from the refined categories were used to reflect on the study topic to answer the research questions. A second member served as a reliability coder to establish the reliability of the initial coder. This analysis was achieved using the qualitative data analysis software MAXQDA to locate any themes or patterns in the audio-recorded interviews.

Ethical Considerations

Ethics can be described as issues about doing what is right or wrong within society. Research ethics, on the other hand, refers to a set of rules that scientific researcher is required to follow when conducting research, and they should do this in a sound and morally manner. This research study was a sensitive one and involved human participants, therefore the researcher was required to abide by certain research ethics outlined in the APA (2014) manual. All ethical guidelines were addressed in writing to all participants before signing the consent form. The researcher was required to ensure privacy for the study participants as well as maintain high levels of confidentiality. As mentioned above, the information obtained during the research study has been stored in lockable cabinets and password-protected computer systems for 5 years after which it will be disposed of by deletion or burning. The participants were allowed to participate voluntarily and not under any coercion, and had the right to terminate their participation at any given point of the study. The researcher used chosen pseudonyms to refer to the participants throughout the study.

Issues of Trustworthiness

Trustworthiness in qualitative research demonstrates that data analysis was conducted using consistent and precise measures by disclosing and recording the methods utilized in the study with sufficient detail so the credibility of the research can be confirmed (Graneheim & Lundman, 2004). According to Graneheim & Lundman (2004), although validity and reliability are the more typical measures of quality in quantitative research, credibility, dependability, confirmability, and transferability are the primary strategies used to validate trustworthiness in a qualitative study. These four strategies are discussed in this section to demonstrate how the data analysis was conducted, and how the results were credible.

Credibility represents how the research findings were determined to be true while establishing the research participant's lived experiences as being plausible and accurate (Houghton et al., 2013). Qualitative research relies on obtaining research data based on information drawn from the research participant's personal views. Not only is it important to ensure the information obtained is credible, but it is also important to ensure the participant's views are correctly interpreted in the data as well (Houghton et al., 2013). Credibility was enhanced by conducting lengthy interviews with research participants to establish a lasting presence while engaging during the interview process. Investing sufficient time with the research participant during the interview process allows the researcher to become familiar with the context, build trust, and test for misinformation (Houghton et al., 2013).

Dependability represents the stability and consistency of the research findings over time (Lincoln & Guba, 1985). According to Graneheim & Lundman (2004), the interpretations and recommendations that result from the study must be supported by the data obtained from the research participants during the study. Dependability was increased by maintaining consistency throughout the research process, documenting any revisions to the research procedures, and maintaining a detailed record of any changes that were implemented throughout the study.

Confirmability refers to the degree to how the research findings can be confirmed by other researchers (Lincoln & Guba, 1985). One of the primary concerns of confirmability is ensuring research findings are not based on the researcher's personal opinion and can be supported by sufficient data (Houghton et al., 2013). The procedure for ensuring dependability and confirmability in a research study is known as an audit trail (Lincoln & Guba, 1985). According to Lincoln & Guba (1985), an audit trail provides a transparent description of the steps taken throughout the research from the beginning to the development and completion of the research findings. Audit trails typically consist of detailed notes taken throughout the study, sampling selection, procedures for collecting data, and data analysis (Lincoln & Guba, 1985). An audit trail was used for my research to support the data collected throughout the study and the final result of the research findings.

Transferability ensures the context of the research is described, in addition to the behavior and experiences of the research participant (Lincoln & Guba, 1985). A process known as the thick description is used to facilitate transferability and ensure the reader

can assess your findings and transfer the results to their setting (Lincoln & Guba, 1985). Transferability in this study included a thick description of the context of the research. Besides, a thick description of the research participants involved in this study was also included.

The researcher considered conducting the interviews at the most suitable time when the participants felt most comfortable, with this being a very sensitive study topic. Before the start of the interviews, the researcher elaborated and explained to the study participants the study purpose and their role in the study, and written informed consent was obtained. The research responded to any concerns the participants had about the study. The researcher also guaranteed the participants confidentiality of their responses and they were referred to using pseudonyms to hide their identity.

Data trustworthiness in qualitative research establishes that the findings from the study are credible, transferable, confirmable, and dependable. This was achieved by ensuring that the findings were solely based on the participant's responses without any potential bias from the researcher. The participants reviewed and examined their interview transcripts to ensure that their responses are consistent.

Summary

This chapter presents a detailed account of the research process for the research study. The study was based on a phenomenological qualitative research design to provide a deep understanding of a phenomenon which is generational poverty and mental health. To answer the research questions, the study utilized interviews conducted using open-ended questions among minority residents of inner-city Chicago. This chapter presented

the research methodology, the rationale for the study, the sampling design, data collection and analysis techniques, issues to do with trustworthiness, and ethical considerations for the research study. All the above-highlighted sections have been described in detail within this chapter.

Chapter 4: Results

The purpose of this research study was to explore the lived experiences and attitudes of minorities living in generational poverty and have a reluctant attitude towards mental health treatment. This phenomenological qualitative study included 10 participants living in inner-city Chicago who were interviewed to understand their experiences that contribute to their attitudes toward mental health treatment. The following research question guided my inquiry:

Research Question 1–Qualitative: What lived experiences contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago?

In this chapter, the demographic characteristics of the research participants as well as a detailed overview of the data analysis, evidence of trustworthiness, data collection, and a summary of the research findings are presented. The lived experiences of the participants are a crucial component of the study because the information allows the attitude of the participants to be explored. Open-ended questions were used to explore the lived experiences from the participant's perspective of growing up in generational poverty as one of the factors that may have shaped their attitude towards seeking professional mental health treatment.

Study Setting

Due to the COVID-19 social distancing mandates, all interviews were conducted virtually using Skype, or by audio communication via telephone. The interviews were completed from my home office, in a quiet and confidential setting. Additionally, the

interviews were conducted without any distractions or interruptions, and participants were asked to confirm if their undivided attention would be maintained throughout the entire interview session. Participants were asked to confirm when they were ready to begin and were reminded that their participation was voluntary. At the time of this study, there were no external factors to negatively impact the quality of the interview process.

Demographics

All participants self-certified that they were aged between 18-65 years, were African American, and had a reluctant attitude towards professional mental health treatment. In addition to the research participants living below the poverty line, the participants confirmed having at least 3 generations of family that has lived in poverty in inner-city Chicago. Each participant was assigned a pseudonym in ascending order of the alphabet (see Table 2).

Table 2

Participant Demographics

Participant	Pseudonym	Age Range	Years Living in Inner City Chicago	Highest Level of Education Completed	Family Generations Living In Poverty
P1	Participant A	25-45	10 or more	Bachelor's	3 or more
P2	Participant B	25-45	10 or more	Bachelor's	3 or more
P3	Participant C	18-24	10 or more	High School	3 or more
P4	Participant D	18-24	10 or more	High School	3 or more
P5	Participant E	25-45	10 or more	High School	3 or more
P6	Participant F	25-45	10 or more	High School	3 or more
P7	Participant G	18-24	10 or more	Elementary	3 or more
P8	Participant H	25-45	10 or more	High School	3 or more
P9	Participant I	18-24	10 or more	Bachelor's	3 or more
P10	Participant J	46-65	10 or more	High School	3 or more

Data Collection

Data were collected over 11 weeks. I received Walden University IRB approval to conduct research on December 21, 2020. A total of 10 participants were recruited to participate in this study. The participants were recruited through advertisements placed on public social media platforms such as Facebook and Twitter, and some participants were recommended by candidates who responded to the advertisements. Advertisements were also placed on Facebook social media groups of minorities who live in Chicago, billboards, and public bus terminals. The bus terminals and billboards were chosen due to the heavy traffic of the targeted population. The advertisements remained posted until the required number of participants was obtained. Participants showing interest in taking part in the study received a request to participate in the study via email or text, which comprised of some screening questions to ensure they met the selection criteria for the study. There were no unexpected variations in the data collection process, nor were there any unusual circumstances encountered.

Data Analysis

Purposive sampling was used to recruit the study participants based on their availability, and snowballing sampling was used to expand the sample size where the identified participants or informants were requested to recommend others who met the inclusion criteria to participate in the study. Four participants were recruited using purposive sampling, while six participants were recruited using snowballing sampling. Before the interviews began, the participants were first presented with the consent forms

via electronic mail, which they were required to carefully read, understand, sign, and return to the researcher.

To ensure social distancing needs were met, virtual meetings were the only form of engagement for completing the interviews. The participants were asked 14 questions from the interview questionnaire and were audio-recorded with each interview lasting approximately one hour. All interview questions corresponded to the research question for the study and allowed the participants to address their experiences in detail regarding their familial generations that have lived in poverty in inner-city Chicago. The interview questions also allowed the participants to provide details on their attitude towards mental health treatment and the attitudes of their families that are living in poverty in inner-city Chicago.

Interviews were recorded, with permission from the participants, and transcribed using audio to text automatic transcription service. Inductive coding was utilized for this study to allow codes to be created from the qualitative data arising from the participant's responses. While creating the codes, labels were assigned to words or phrases to represent important or recurring themes for the responses. The interview responses were then assigned into categories and themes. The themes were identified by first looking over the created codes and identifying patterns within the codes. The coding and analysis were achieved using the qualitative data analysis software MAXQDA to locate any themes or patterns in the audio-recorded interviews.

Each participant was assigned an alphabet pseudonym ranging from A-J, and all interviews were labeled based on their alphabet allocation (Interview A, Interview B,

etc). The transcripts for each participant were transferred into eleven Microsoft Word documents, one file for each participant. The content of each interview was then thoroughly examined to become more familiar with their stories and highlight any impactful statements that pertain to the research.

Discrepant Cases

All participant responses regarding their attitude towards mental health treatment and their lived experiences were similar. None of the participants provided information that was not anticipated in the interview responses. There were no discrepant cases found during this research study.

Issues of Trustworthiness

Trustworthiness in qualitative research demonstrates that data analysis was conducted using consistent and precise measures by disclosing and recording the methods utilized in the study with sufficient detail so the credibility of the research can be confirmed (Graneheim & Lundman, 2004). According to Graneheim and Lundman (2004), although validity and reliability are the more typical measures of quality in quantitative research, credibility, dependability, confirmability, and transferability are the primary strategies used to validate trustworthiness in a qualitative study. These four strategies are discussed in this section to demonstrate how the results were credible.

Credibility represents how the research findings were determined to be true while establishing the research participant's lived experiences as being plausible and accurate (Houghton et al., 2013). In this study, obtaining research data based on information drawn from the research participants relied on their personal views. Not only is it

important to ensure the information obtained is credible, but it is also important to ensure the participant's views are correctly interpreted in the data (Houghton et al., 2013).

Dependability represents the stability and consistency of the research findings over time (Lincoln & Guba, 1985). According to Graneheim and Lundman (2004), the interpretations and recommendations that result from the study must be supported by the data obtained from the research participants during the study. Dependability was enhanced by maintaining consistency throughout the research process, documenting any revisions to the research procedures, and maintaining a detailed record of any changes that were implemented throughout the study.

Confirmability refers to the degree to how the research findings can be confirmed by other researchers (Lincoln & Guba, 1985). One of the primary concerns of confirmability is ensuring that research findings are not based on the researcher's personal opinion and can be supported by sufficient data (Houghton et al., 2013). The procedure for ensuring dependability and confirmability in a research study is known as an audit trail (Lincoln & Guba, 1985). According to Lincoln & Guba (1985), an audit trail provides a transparent description of the steps taken throughout the research from the beginning to the development and completion of the research findings. Audit trails typically consist of detailed notes taken throughout the study, sampling selection, procedures for collecting data, and data analysis (Lincoln & Guba, 1985). The audit trail for this research was maintained to support the data collected throughout the study and the final result of the research findings.

Transferability ensures the context of the research is described, in addition to the behavior and experiences of the research participant (Lincoln & Guba, 1985). A process known as the thick description is used to facilitate transferability and ensure the reader can assess your findings and transfer the results to their setting (Lincoln & Guba, 1985). Transferability was included in this study by including a thick description of the context of the research. Besides, a description of the research participants involved in the research study was presented.

Interviews were conducted at the most suitable time when the participants felt most comfortable since the research was based on a potentially sensitive subject. Before the start of the interviews, any questions or concerns the participants had were addressed. The confidentiality of the participant's responses was also guaranteed and they were assured pseudonyms would be used to hide their identity. The participants were also allowed to review and examine their interview transcripts to ensure that their responses were consistent.

Results

After the 10 interview transcripts were reviewed, a total of 54 codes were identified among 942 quotations located in the participant's responses. Codes in each interview that helped answer the research question, (What lived experiences contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago?) were identified by notating the occurrences of pertinent words or phrases that surfaced during the coding process. A list was first organized to include the 54 codes that emerged (See Table 2).

Figure 1

First Round of Coding

Codes	
Strong	Kids
Stress	Suicide
Drink	School
Smoke	Single Parent
Depressed	Help
Push through	Experience
Party	Attitude
Jail	I feel
Arrest	I need
Love	I can't
Fight	I don't
Argue	I would
Relationship	I might, maybe
Hard	I wouldn't
Drugs	Grandmother
Poverty	Grandfather
Poor	Momma
Struggle	Father
Foster care	Family
Money	White people
Growing up	White Neighborhood
Mental Health Treatment	Faith
Therapy	Mother
therapist	Pray
Trust	Fault
Judge	God
Mom	Granny
Dad	

After thoroughly reviewing the initial list of codes, words that had a similar meaning were grouped. For instance, words such as momma and mother were combined. The number of occurrences each word or phrase was located in the interview transcripts was recorded (See Table 3).

Figure 2

Second Round of Coding

Codes	
Strong (9)	Kids (47)
Stress (19)	Suicide (6)
Drink (40)	School (26)
Smoke (2)	Single Parent (4)
Depressed (6)	Help (118)
Push through (8)	Experience (25)
Party (6)	Attitude (51)
Jail (6)	I feel (9)
Arrest (4)	I need (14)
Love (15)	I can't (1)
Fight (19)	I don't (2)
Argue (4)	I would (26)
Relationship (7)	I might, maybe (11)
Hard (5)	I wouldn't (2)
Drugs (21)	Grandmother/granny (17)
Poverty (37)	Grandfather (3)
Poor (2)	Mom/mother/momma (116)
Struggle (3)	Father/dad (38)
Foster care (2)	Family (76)
Money (18)	White people (15)
Growing up (25)	White Neighborhood (25)
Mental Health Treatment (91)	Faith (1)
Therapy/therapist (78)	Pray (12)
Trust (17)	Fault (9)
Judge (14)	God (16)

Once the codes were re-organized and the occurrences recorded, the codes were organized into themes by categorizing words and phrases based on a similar meaning. The participant's perceptions and lived experiences based on relativity and relevance to the research topic were characterized. A total of six themes emerged, including two subthemes (See Tables 3 and 4).

Table 3

Themes

Coping Mechanisms	Upbringing	Attitude/Perception	Religion
Strong	Poverty	Help	God
Stress	Poor	I feel	Faith
Drink	Struggle	I need	Pray
Smoke	Foster Care	Attitude	Fault
Depressed	Money	I can't	
Push through	Growing Up	I don't	
Party		I would	
Arrest		I might/maybe	
Love		I wouldn't	
Fight		Kids	
Argue		School	
Relationship		Single parent	
Hard		Kill/suicide	
Drugs			

Table 4

Subthemes

Mistrust	Family Involvement
White People	Mom/mother/momma
White Neighborhoods	Dad/father
Therapy/therapist	Grandmother/granny
Trust	Family
Mental Health Treatment	Grandfather
Judge	

Theme 1: Coping Mechanisms

To answer the main research question, Theme 1 was derived from the participant responses to the interview questions and they describe the coping mechanisms they undertook to safeguard their mental health rather than seek professional help. Coping mechanisms further described the situations the participants experienced and considered as part of their daily life such as drinking, fighting, partying, and getting arrested. Participant C stated:

> My dad he always had like anger problems, he got arrested for murder when I was like 6. He still in jail but my mom she likes to drink a lot and the drinking is worse when she have money problems. But the thing is like, I remember being a kid and she would drink a lot and we would fight like fist fight. We'd blow up like fight to the blood when I was a teenager and I remember like being a kid that

> I got called b**** so much like I ain't even think anything of it like I started thinking it was normal you know to be called that. So when I was in high school that's what I did. If somebody said something I ain't like, I'm ready to fight. Teacher, security guard, it was whatever to me. But the thing is like my momma never thought it was wrong so there was no reason for her to get treatment. She thought this was normal because this is how my grandma was with her you know what I'm saying so it was like no one ever thought of like mental health treatment because this is just how she is.

All the interview responses included either dysfunctional coping strategies or that they developed an attitude that they had to cope with their problems alone because they felt nobody cared. The "push through" mindset was also a common response among the interviews for those living in generational poverty. Participant E stated:

> Nobody will help me. This is something that I just learned throughout life it's just up to me to just get things done and just push through and get through whatever I'm going through. Nobody wanna hear me complaining, nobody cares. At the end of the day I can vent to somebody but venting might make me feel better, but it's not gonna help me, it's not gonna change my situation. Interview G stated:
>
> I really don't have any steps for my health. I just kind a got to roll through it because it's just me, everything is on me. Taking care of my kids is all me, making sure everything gets taken care of is on me. So my mental health comes last. I don't want to say it's not important but it's not a priority because it can't be

priority. I just have to roll with it and take things how they come because I'm all I got and I'm all my kids got.

Theme 2: Upbringing

To further describe the lived experiences contributing to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago, Theme 2 emerged from the interview questions as they explained how they witnessed family members handle mental health issues and poverty. The participant's described what they learned about mental health treatment from their families. For most participants, commonalities began to emerge regarding the difficulties experienced while growing up, and what was considered the cultural norm. Participant C stated:

> I remember my grandad use to get drunk and beat up my granny a lot. I remember my mom always getting into bad fights with her boyfriend's when she drink. The guy would always come back crying, saying he's sorry, he's just depressed and going through a lot. The only times I ever seen my mother cry was when she was drunk, the only time my mother ever told me she loved me is when she was drunk. Damn. I guess everybody I know communicates better when they drunk.

Interview H stated:

> I never really had a close relationship with my mama. She was there, but she wasn't there if that makes any sense. She was there, but as far as teaching me right from wrong and she didn't do none of that. That was all on my grandmother cause my mother was in the streets, party type of person. Don't get me wrong I love my

> momma, it's just hard for people to give something they never had themselves you know.

Participant B shared similar experiences with witnessing how the family handled mental health issues and poverty and further elaborated how his mom would often relapse on drugs and lash out whenever she was overwhelmed or depressed. It wasn't until he moved with his uncle at 9 that he learned how to productively express his feelings. Further, the participant credits his uncle for being the reason he learned how to productively manage stress and anger. However, the constant battle between witnessing how his mother handled stress and his uncle's guidance often led him to struggle between right and wrong. To further support these sentiments participant D stated:

> My mother started using drugs when I was really young that's why DCFS took us away and then after that when she was on drugs like she was real depressed before that but that's how she handled it she used crack, leave for days, come back and yell at us when we said she needed help. She said it was our fault for stressing her out. So we just got used to it you know. She lose her job, she'll be gone getting high for days. We get into trouble, she'll be gone getting high for days. The only time I saw my mother getting therapy or something like that was against her will it was court ordered because she got arrested so yea that was the only time I will see my family go get counseling or help is when it was court ordered or something like that.

Subtheme: Family Involvement

The participant responses regarding their upbringing resulted in several statements about the role generational poverty played in their family's attitude towards professional mental health treatment. For the majority of participants, the grandmother was charged with the primary responsibility of assisting the family in coping, allowing vulnerability, and retaining resiliency. Participants A, C, D, E F, G, and J all mentioned that speaking to their grandmother (maternal/paternal) was the only time they could express themselves and be vulnerable without being judged as weak by the rest of the family. Besides, due to a lack of financial resources and trust over several generations, families sought solace solely in the matriarch of the family.

Theme 3: Attitude

Theme 3 emerged from the participants' responses when exploring their lived experiences contributing to the attitudes toward mental health treatment. The participants described their perception of seeking therapy, the personal experiences that led to their attitude towards professional mental health treatment, and the role their community plays in their attitude towards mental health treatment.

Participant F stated:

> I don't know of any places to go for it [therapy] that's what I'm saying. I don't know of any place in the hood. I ain't never seen no s*** like that around here man you can drive through my hood for 20, 30 minutes straight you ain't gone see not 1 therapy office, counselor office, none of that. You might see a couple plan parenthood clinics or some s***but that's it. You got to go somewhere like Lincoln Park, north side, for something like a therapy office. If

they don’t even care enough to come to this area why would I care enough to get help from them.

Participant E stated:

I feel like if I do ever need therapy I gotta find it and I'll have to go to like a white neighborhood. And if I do that 9 times out of 10 they not gonna be able to help me anyway because they not gonna even understand me. They will be looking at me like I'm crazy. You know and at the end of me venting to somebody is it like, OK now that I let you vent OK, let me give you you know blah blah blah to help you, you know. Let me help you, let me know what I can do to help, or give me your résumé. That’s not what happens at the end of therapy so it's like what am I about to go take trains and buses to somebody office to talk to them and they can’t really help me. I’m depressed cause I need a job. You gone give me a job?

Participant C stated:

My baby daddy used to always tell me that I should never tell people about my problems cause most people glad it’s you and not them, and everybody else don’t care. Growing up, I learned I’m on my own and nobody cares what I’m going through.

Participant G stated:

I don't really know nothing about therapy. Nobody's ever told me about therapy, I don't know anything about it. I've never seen therapy over here. I don't know anything about it. I never thought about going to actually get therapy or anything like that because I don't even, I wouldn't even know how to do that. I just think

> that just seem like something they give to normal people. I think you have to you know be a schizophrenic or something. I grew up in this area 86 and commercial all my life you know my mama from here we all from here I never ever heard anything about therapy. I never heard nobody talk about therapy, my friends, my family, I never heard of that as an option. I've never seen that growing up either, even when I go to the to the doctor when I was pregnant. Nobody even let me know that was an option for me to go talk to somebody.

Subtheme: Mistrust

The participants' responses regarding their attitude towards mental health treatment revealed several aspects about their lack of trust towards professional mental healthcare providers. Besides, trust issues also surfaced when the participants were asked if they would ever seek therapy if they needed it, and what changes would need to occur in the mental healthcare field for them to desire to seek mental health treatment if needed.

Participant I stated:

> So growing up in foster care I ain't really know who home I was gone be in so I, I never really had somebody to trust to talk to so, other than my grandmother. When I could I stayed with my grandmother, that was my saving grace. She was the one when I was growing up, and I know even now she the one that is there to talk to me when I needed somebody to talk to, but as far as strangers no stranger I can say other than one person. I probably like 20 or more caseworkers in my whole childhood and only one of them I can think of that was really good. But every stranger I ever come across they've never did anything to really try to help

> me. They was either just keeping me for money or you know they just kind of would use what I would tell them like against me just like all my other caseworkers. So, when I was little I would tell them I was you know hurt or I was upset I was scared and they go tell the family I was living with that I said it, and now they really treating me bad you know. So, I learned not to trust the system because they just use it against you.

Issues regarding mistrust were primarily derived from lack of cultural representation, fear of judgment, and the distance required to travel to obtain professional mental health treatment. The participants who admitted to receiving therapy in the past stated they felt judged because the therapist could not relate to their experiences.

Participant H stated:

> I don't trust them. I think and I really I know from experience they either will use it against you, or they just gonna sit there and judge you and give you like some half a** answers to keep you coming back, to keep getting that co-pay so they want to you know, draw it out. And then even if it's something you healed through they want to rehash it for them, and they wanna see you suffer through it again. Or, they just judging you because they don't get it. I never been with a therapist that look like me. I never been to a therapist that was a black dude you know, or grew up where I grew up. I never seen that for me or nobody.

Theme 4: Religion

Theme 4 emerged when exploring the role generational poverty has played in the personal mental health of the participants, and what they learned about mental health

treatment from their family members. Several participants mentioned having issues with lack of accountability as adults and among family members. Participants A, C, D, E, H, I, and J all regarded religion as a primary resource for their family members when issues arise regarding mental health. participant J stated:

> I kind of grew up believing that mental health and religion can't exist in the same house, and it's because you got something that you need to get right with God. I don't know nobody in my family that ever tried to get no mental therapy. I don't know nobody that did nothing like that at all. I witnessed family handling mental issues though. My dad had a real bad drinking problem and my mother was a punching bag in a way an emotional punching bag. I saw her depressed a lot, and I saw him you know drink a lot. He'd act a fool Monday through Saturday and then go to church on Sunday and be holier than thou like nothing ever happened the whole week. It was just like a repeat throughout my whole childhood. I learned that a lot of people can do a lot of bad things in the name of their religion.

Participant A stated:

> Black people don't get mental treatment or nobody care about what's going on with a black person. You go to church to pray on it, you get right with God and that's just how you set your mental health straight. God will heal all God will provide. God forgives, so even if you making bad decisions that are hurting you or hurting other people it was like, oh yeah well nobody has the right to judge. That was always the excuse, so I was taught to put it into the hands of God, do

whatever you want just put it into the hands of God. Whatever you got going on is cause you not going to church enough or you not praying enough.

Summary

In Chapter 4, the reluctance to seek mental health treatment among minorities living in generational poverty was explored. Following data collection, coding, and transcription, six themes emerged that included, Coping Mechanisms, Upbringing, Family Involvement, Attitude, Mistrust, and Religion. These themes aimed at answering this study research question: What lived experiences contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago? The interview responses provided in-depth information regarding the reluctance of participants towards seeking mental health treatment if they ever needed it. Several aspects emerged regarding their personal experiences, the behavior witnessed among family members displaying mental health problems, and how mental health was addressed in their community.

Mistrust, along with culturally inherited coping mechanisms shaped many of the participants' responses when explaining their current attitude towards mental health treatment. While upbringing, religion, and family involvement supported many lived experiences that contributed to their attitude over time. All participant's expressed variations in reluctance towards professional mental health treatment.

In Chapter 5, the results of this research are discussed. The findings are solely based on the participant's responses to the interview questions regarding the lived experiences that have contributed to their attitude towards mental health treatment in

inner-city Chicago. The study limitations, implications for social change, and recommendations for future research are also discussed.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this research study was to explore the lived experiences and attitudes of minorities who are living in generational poverty and have a reluctant attitude towards mental health treatment. In particular, the research question addressed was: What lived experiences contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago? This phenomenological qualitative study included 10 participants living in inner-city Chicago who were interviewed to obtain their experiences that contribute to their attitudes toward mental health treatment. After an in-depth analysis of the research findings, four themes and two subthemes emerged. The themes were: coping mechanisms, upbringing, attitude, and religion. The two subthemes were family involvement and mistrust.

Interpretation of the Findings

The common sense model (CSM) is a theory that suggests that people have common-sense beliefs about illnesses based on personal experience, formal education, cultural traditions, and stories from family and friends (Ward & Heidrich, 2009). Research that has focused on African African Americans and mental illness found a long history of negative attitudes toward mental illness and stigma associated with seeking professional mental health services (Ward & Heidrich, 2009).

Coping Mechanisms

All of the participants expressed various levels of reluctance towards professional mental health treatment based on personal experiences, cultural influence, and coping mechanisms utilized by family members. Several participants mentioned how they grew

up witnessing their family and community cope with depression, stress, and other mental health concerns by drinking, fighting, or using drugs. Although the typical approach utilized by their parents and maternal/paternal grandparents is considered to be dysfunctional, the participants admitted to exhibiting the same behavior whenever they felt depressed, stressed, or overwhelmed. Many participants felt an urgency to 'push through' any mental health concerns they were experiencing because there was no one they could trust to confide in, thus the majority of participants reported to similar coping mechanisms.

Mistrust

A previous Illness Perception Questionnaire-Revised (IPQ-R) administered to 180 African American men and women, revealed that one of the leading causes of minorities being reluctant to seek mental health treatment was mistrust (Ward, 2013). When the participants in my study were asked about their perception of professional mental health treatment, seven out of the 10 participants stated they did not trust the system. Besides, the participants also stated they would consider therapy if they needed it, and only if the therapist was close to their home and was African American. According to Scharff et al. (2010), there is a history of medical experimentation and abuse among African Americans in research studies that extends more than 4 centuries. The lack of cultural diversity and competency among mental health professionals is also considered to be a major contributor to African Americans mistrust in the medical research and health care infrastructure (Scharff et al., 2010).

The mistrust of clinical and health professionals is also influenced by negative encounters with health care providers. There has been ample documentation regarding discriminatory and racist practices among individual clinicians (Wendt et al., 2014). Two participants mentioned having an adverse experience with the professional system through foster care or when seeking a therapist in the past. The experience led the participants to not trust mental healthcare providers because they felt they would be judged or misunderstood.

Attitude

The participants who had considered trying professional mental health treatment in the past expressed concern and reluctance due to apprehension about potentially paying for a therapist who cannot relate to their problems and does not take their feelings seriously. Based on the APA's multicultural guidelines and traditional Eurocentric interventions, the therapy models that are used to train most therapists may be harmful or ineffective to culturally diverse individuals (Wendt et al., 2014). Ethnic minorities receive less empathy, information, and attention than their White counterparts (Scharff et al., 2010). African Americans are also less likely to receive medical services than White patients who complain about similar symptoms (Scharff et al., 2010).

Another commonality among the participant's responses was the lack of availability for professional mental health treatment in their communities. All of the participants stated they were not aware of, nor had ever seen mental health services in their inner-city neighborhood. The mental health services in Chicago have consistently decreased (Watson et al., 2017). In 2016, Chicago went from having 12 mental health

facilities to only having five, with several of the closed facilities being located in low-income African American neighborhoods (Quinn, 2018).

Religion

Many African Americans prefer to use the church as a coping mechanism for mental and emotional problems instead of seeking professional mental health treatment (Hays, 2015). Black churches are considered to be a trusted institution and are considered to be a protective factor for mental health in the African American community (Hays, 2015). According to Hays (2015), African Americans have primarily been taught to cope and seek help from God instead of seeking professional mental health treatment. African Americans rely on prayer, reading the bible, religious music, and attending church services. In some cases, professional mental health treatment can be viewed by church members as a lack of faith in God (Hays, 2015). Participant J stated, "I kind of grew up believing that mental health and religion can't exist in the same house, and it's because you got something that you need to get right with God."

Although religion is typically viewed as the primary reason African Americans are reluctant to seek treatment, seven out of 10 interviews perceived mental health as an isolated responsibility that the participants had to address alone. The 'push through' rhetoric was mentioned numerous times in conjunction with stating no one else truly cared about the issues they were experiencing and the participants felt they had no choice but to cope with mental health issues alone.

Limitations of the Study

The phenomenological qualitative research design was used to interview 10 participants living in generational poverty in inner-city Chicago, with a reluctant attitude towards professional mental health treatment. All participants resided in inner-city Chicago and had a family lineage of at least 3 generations that had resided in inner-city Chicago. The specific recruitment requirement based on geography may provide limited representation for minorities residing in an inner-city neighborhood outside of the Chicago land area. Another limitation of this study was the recruitment of participants meeting the basic criteria set before participating in the interviews, whereby some participants may have ended up providing false information about the family income level. There was also a potential limitation regarding the willingness of the participants to share genuine experiences about generational poverty within their families which might also pose a great challenge. The participants were required to self-certify their current income level, family lineage, and current attitude towards professional mental health treatment.

According to Creswell and Poth (2016), phenomenological studies should have between 5-25 participants while Morse (2000) suggests at least six participants. Therefore, 10 African Americans living in generational poverty were recruited for this research study. No limitations were encountered regarding the required sample size when recruiting participants. The required saturation was achieved by utilizing the snowballing sampling method. However, the lack of randomization provided less opportunity for the

results to be generalized to the African Americans who are not living in generational poverty.

Recommendations

For this research study, a phenomenological research method was used to explore the lived experiences of minorities living in inner-city Chicago that contributed to their attitude towards professional mental health treatment. A total of 10 participants currently living in poverty, and also had a family lineage of generational poverty that spanned at least 3 generations were recruited. One of the recommendations for future research to build on this study is to refrain from limiting the participant sample to one particular geographical location, and including African Americans from several inner-city neighborhoods throughout the United States. Research on African Americans residing in several inner-city neighborhoods allows an in-depth analysis of the participant's lived experiences and exposes potential commonalities regarding attitude, current socioeconomic status, and family lineage of generational poverty. Including multiple inner-city neighborhoods could also establish a pattern being experienced by other minorities as the participants in Chicago.

Implications

Poor mental health is a key component associated with generational poverty (Cheng, 2016). Adults who suffer from mental health issues are more likely to have a child with mental health problems (Cheng, 2016). A family's cognitive ability is reduced by more than half when exposed to two or more consecutive generations of poverty (Sharkey, 2011). Families that suffer from mental illness have a lower socioeconomic

status (SES) than families without mental illness, leading to a decrease in academic success, social achievement, and the ability to become gainfully employed (Cheng, 2016). To help resolve the generational poverty cycle in poor neighborhoods, the cultural norms that have been inherited for addressing mental illness must be dissolved.

If African Americans utilize professional mental health services, future generations can benefit from a home environment where the mental health of the parental figure is being addressed, potentially leading to a more stable home life. If experiencing poor mental health is associated with the inability to retain employment, substance abuse, and depression, strengthening the mental health state of African American families living in generational poverty can address re-occurring issues in the home and the community. The personal views and concerns of African Americans living in generational poverty were explored using interviews and open-ended questions. Obtaining personal viewpoints and experiences allow the lack of mental health treatment among African Americans in poor neighborhoods to be viewed from different perspectives.

Many programs address the impact of experiencing generational poverty in inner-city Chicago (i.e. additional policing, welfare-to-work, public assistance) but very few address the underlying cause. To promote change within an environment, it is important to engage with the group being studied. Personal engagement leads to a better understanding of a group's opinions, situations, and insights instead of just predicting their behavior (Erickson, 2011).

Based on the research findings, attitudes, and interview responses shared during this research study, one of the recommendations is that education regarding the role and

purpose of professional mental health treatment be implemented into any health services offered to African Americans living in inner-city Chicago. Several of the research participants made negative assumptions about the role of mental health treatment because they had never had anyone discuss therapy as a viable option for addressing potential mental health issues, nor did the participants ever encounter any advertisements in their neighborhoods to advocate the benefits of professional mental health treatment. Major commonalities among the participants living in generational poverty were having one or more children and the receipt of welfare benefits. This commonality provides locations such as physician offices and welfare facilities opportunities to provide educational information and potential referrals to any African American living in generational poverty to seek professional mental health treatment if needed.

Another recommendation is the use of and promoting black representation among therapists in the mental health field. Cultural representation was a consistent concern among all the research participants. The research participants often made statements of being apprehensive about potentially visiting a therapist that would not understand them, or judge them because the therapist was not familiar with their upbringing or environment. Promoting mental health services in inner-city neighborhoods by showcasing the availability of African American therapists can make the residents more comfortable with pursuing treatment.

Lastly, there are very few mental health facilities available to the residents in inner-city Chicago. In 2016, Chicago went from having 12 mental health facilities to only having five, with several of the closed facilities being located in low-income African

American neighborhoods (Quinn, 2018). Participants mentioned the likeliness of having to travel far distances to more prominent neighborhoods if they ever needed professional mental health treatment. Providing mental health treatment within the inner-city neighborhood could potentially make residents more inclined to seek treatment if needed.

Conclusion

The purpose of this phenomenological research study was to explore the lived experiences that contribute to the attitudes toward mental health treatment among minorities living in generational poverty in inner-city Chicago. The 10 participants recruited into this study provided detailed accounts of their lived experiences with generational poverty, mental health, and the experiences their family lineage had shared with them regarding professional mental health treatment. Ultimately, all the participants also offered information about how mental health issues were typically addressed in their families and their community. Commonalities emerged as each participant individually described a reluctant attitude towards professional mental health treatment. The participants mentioned witnessing and displaying similar coping mechanisms when dealing with mental illness in the past such as drinking, violence, drugs, and unstable home life.

Sharkey (2011) determined during a cognitive study on Chicago youth that the influence of disadvantaged neighborhoods lingers in children, even if they move to a more diverse neighborhood. If the child's caregiver was raised in a similar disadvantaged environment, the parent's childhood environment can influence the next generation (Sharkey, 2011). The most impactful social change occurs when the cultural norms and

behavior patterns of a group are altered over an extensive period. Addressing the lack of professional mental health treatment among African Americans living in generational poverty in inner-city Chicago can promote social change by addressing any dysfunctional coping mechanisms in regards to mental illness, and replacing the dysfunction with productive emotional outlets, healthy communication, and problem-solving techniques. A shift in the mindset of the parents can potentially be passed down to the children, creating future generations that prioritize healthy coping mechanisms. If a parent is comfortable with discussing mental health concerns and obtaining mental health treatment, their children may be influenced by this positive perspective just as much as children who are currently affected and influenced by their disadvantaged environment.

Exploring the lived experiences that contribute to the attitudes toward mental health treatment among minorities living in generational poverty can potentially provide the reasons for not seeking mental health treatment, and could alleviate the symptoms associated with poor mental health such as psychological distress, severe depressive episodes, poverty, and violence. Reduction in mental health care disparities can restore African Americans trust in clinicians and encourage African Americans to seek professional mental health treatment when needed. If adults living in generational poverty are willing to seek treatment, they can encourage their children and other family members to obtain treatment as well. There have been several programs implemented in inner-city Chicago to assist with the outcomes of living in generational poverty (i.e., lack of employment, substance abuse, crime) (Rankin & Quane, 2000). Such programs include economic security programs such as housing subsidies, tax credits for working families,

and food aid. All these reforms are intended to seemingly respond to urban poverty. However, if social change is not implemented to address the mental health of the families living in generational poverty, they will continue to suffer and this will continue to affect their mental health status and productivity (Owens & Clampet-Lundquist, 2017).

References

Akhtar, S. (2012). *The African-American experience: Psychoanalytic perspectives*. Jason Aronson.

Aliprantis, D., & Kolliner, D. (2015, April 16). *Neighborhood poverty and quality in the Moving to Opportunity experiment.* Federal Reserve Bank of Cleveland. https://www.clevelandfed.org/newsroom-and-events/publications/economic-commentary/2015-economic-commentaries/ec-201504-neighborhood-poverty-and-quality-in-the-moving-to-opportunity-experiment.aspx

Aliprantis, D., & Zenker, M. (2011, December 21). *Concentrated poverty.* Federal Reserve Bank of Cleveland. https://www.clevelandfed.org/newsroom-and-events/publications/economic-commentary/economic-commentary-archives/2011-economic-commentaries/ec-201126-concentrated-poverty.aspx

Alisic, E., Zalta, A. K., Van Wesel, F., Larsen, S. E., Hafstad, G. S., Hassanpour, K., & Smid, G. E. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: Meta-analysis. *The British Journal of Psychiatry*, *204*(5), 335–340. https://doi.org/10.1192/bjp.bp.113.131227

American Psychological Association. (2014). Demographic characteristics of APA members by membership characteristics. http://www.apa.org/workforce/publications/14-member/table-1.pdf

Anderson, E. (2012). The iconic ghetto. *The Annals of the American Academy of Political and Social Science, 642,* 8-24. http://dx.doi.org/10.1177/0002716212446299

Astalin, P. K. (2013). Qualitative research designs: A conceptual framework. *International Journal of Social Science and Interdisciplinary Research*, *2*(1), 118 124.

Azibo, B. R., & Amungwa, F. A. (2019). Applying Relativity in Understanding Poverty and Promoting Economic Development in Rural Africa. *African Journal of Economic Review*, *7*(1), 219-237.

Beeber, L. S., Perreira, K. M., & Schwartz, T. (2008). Supporting the mental health of mothers raising children in poverty. *Annals of the New York Academy of Sciences*, *11*(3),86-100. https://doi.org/10.1196/annals.1425.008

Biener, A. I., & Zuvekas, S. H. (2019). Do racial and ethnic disparities in health care use vary with health? *Health Services Research*, *54*(1), 64-74. https://doi.org/10.1111/1475-6773.13087

Boustan, L. P. (2013). Racial residential segregation in American cities. National Bureau of Economic Research, 4-18. https://doi.org/10.3386/w19045

Boylorn, R. M. (2008). Lived experience. *The Sage Encyclopedia of Qualitative Research Methods.* SAGE Publications.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Bucca, M. (2016). Merit and blame in unequal societies: Explaining Latin Americans' beliefs about wealth and poverty. *Research in Social Stratification and Mobility*, *44*, 98-112. https://doi.org/10.1016/j.rssm.2016.02.005

Cheng, T. L., Johnson, S. B., & Goodman, E. (2016). Breaking the intergenerational cycle of disadvantage: The three-generation approach. *Official Journal of Pediatrics. U.S. National Library of Medicine,* 137(6), 1-8. https://doi.org/10.1542/peds.2015-2467

Cicchetti, D., & Natsuaki, M. (2014). Multilevel developmental perspectives toward understanding internalizing psychopathology: Current research and future directions. *Development and Psychopathology, 26*(4pt2), 1189-1190. https://doi.org/10.1017/S0954579414000959

Comerchero, V. A. (2016). Going the extra mile: Enhancing lives of at-risk minority youth. *American Psychological Association*, *61*(1), 1-5. https://doi.org/10.1037/a0039908

Creswell, J. W., Hanson, W. E., Clark Plano, V. L., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The Counseling Psychologist*, *35*(2), 236-264. https://doi.org/10.1177/0011000006287390

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed-methods approaches* (4th ed.). Sage. https://doi.org/10.5539/elt.v12n5p40

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Draine, J. (2013). Mental health, mental illnesses, poverty, justice, and social justice. *American Journal of Psychiatric Rehabilitation*, 16(2), 87-90. https://doi.org/10.1080/15487768.2013.789684

Elliott, I. (2016). Poverty and mental health: a review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy. *London: Mental Health Foundation*, 1-110.

Erickson, F. (2011). A history of qualitative inquiry in social and educational research. In N. Denzin, & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., pp. 1-44). Thousand Oaks, CA: Sage Publications, Inc.

Eshun, S., & Packer, E. M. (2016). Positive psychology practice with African Americans: Mental health challenges and treatment. In E. C. Chang, C. A. Downey, J. K. Hirsch, & N. J. Lin (Eds.), Positive psychology in racial and ethnic groups: Theory, research, and practice. (pp. 259–279). Washington, DC: American Psychological Association. https://doi.org/10.1037/14799-013

Evans, G. W., & Kim, P. (2013). Childhood poverty, chronic stress, self-regulation, and coping. *Child Development Perspectives, 7*(1), 43–48. https://doi.org/10.1111/cdep.12013

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The qualitative report*, 20(9), 1408-1416. https://doi.org/10.46743/2160-3715/2015.2281

Galea, S., Tracy, M., Hoggatt, K. J., DiMaggio, C., & Karpati, A. (2011). Estimated deaths attributable to social factors in the United States. *American Journal of Public Health*, 101(8), 1456-1465. https://doi.org/10.2105/AJPH.2010.300086

Generaal, E., Timmermans, E. J., Dekkers, J. E., Smit, J. H., & Penninx, B. W. (2019). Not urbanization level but socioeconomic, physical and social neighborhood characteristics are associated with presence and severity of depressive and anxiety

disorders. *Psychological medicine*, *49*(1), 149-161. https://doi.org/10.1017/s0033291718000612

Giddens, A. (2013). *The third way: The renewal of social democracy*. John Wiley & Sons. https://doi.org/10.2307/20049222

Given, L. M. (2008). *The SAGE encyclopedia of qualitative research methods* (Vols. 1-0). Thousand Oaks, CA: SAGE Publications, Inc. https://doi.org/10.4135/9781412963909

Glaser, B., & Strauss, A. (1967). Grounded theory: The discovery of grounded theory. *Sociology the journal of the British sociological association*, 12(1), 27-49.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105-112. https://doi.org/10.1016/j.nedt.2003.10.001

Griffith, D. M., Brinkley-Rubinstein, L., Bruce, M. A., Thorpe, R. J., Jr., & Metzl, J. M. (2015). The interdependence of African American men's definitions of manhood and health. Family & Community Health: The Journal of Health Promotion & Maintenance, 38(4), 284–296. https://doi.org/10.1097/FCH.0000000000000079

Grusky, D. B., & Weisshaar, K. R. (2014). *Social stratification: Class, race, and gender in sociological perspective (4th ed.)*. Boulder, CO: Westview Press. https://doi.org/10.4324/9780429306419

Gugushvili, A. (2016). Intergenerational social mobility and popular explanations of poverty: A comparative perspective. *Social Justice Research*, 29(4), 402-428. https://doi.org/10.1007/s11211-016-0275-9

Hanna, R., & Karlan, D. (2017). Designing Social Protection Programs: Using Theory and Experimentation to Understand how to Help Combat Poverty. In *Handbook of Economic Field Experiments* (Vol. 2, pp. 515-553). North-Holland.

Hassan, Z. A., Schattner, P., & Mazza, D. (2006). Doing A Pilot Study: Why Is It Essential? *Malaysian family physician: the official journal of the Academy of Family Physicians of Malaysia*, 1(2-3), 70–73.

Hawthorne, W., Folsom, D., Sommerfeld, D., Lanouette, N., Lewis, M., Aarons, G., Jests, D. (2012). Incarceration among adults who are in the public mental health system: Rates, risk factors, and short-term outcomes. Retrieved from: https://doi.org/10.1177/0093854817704452

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case study research. *Nurse Researcher*, *20*(4), 12-17. https://doi.org/10.7748/nr2013.03.20.4.12.e326

Hunt, M. O., & Ray, R. (2012). Social class identification among black Americans: Trends and determinants, 1974–2010. *American Behavioral Scientist*, 56(11), 1462–1480. https://doi.org/10.1177/0002764212458275

Hunter, M. A., & Robinson, Z. F. (2016). The sociology of urban Black America. Annual Review of Sociology, 42, 385–405. https://doi-org./10.1146/annurev-soc-081715-074356

Hwang, J., & Sampson, R. J. (2014). Divergent pathways of gentrification: Racial inequality and the social order of renewal in Chicago neighborhoods. American Sociological Review, 79(4), 726–751. https://doi.org/10.1177/0003122414535774

Kao, T. Y., Chen, J. C., Wu, J. T. B., & Yang, M. H. (2016). Poverty reduction through empowerment for sustainable development: A proactive strategy of corporate social responsibility. *Corporate Social Responsibility and Environmental Management*, 23(3), 140-149. https://doi.org/10.1002/csr.1365

Kelch-Oliver, K. (2011). The experiences of African American grandmothers in grandparent-headed families. *The Family Journal*, 19(1), 73–82. https://doi.org/10.1177/1066480710388730

Kneebone, E., & Lou, C. (2014). Suburban--and poor. The changing landscape of race and poverty in the U.S. *American Planning Association*, 80(6), 16-21. Retrieved from: https://www.planning.org/planning/2014/jun/suburbanandpoor.htm

Kohn-Wood, L., & Hooper, L. (2014). Cultural competency, culturally tailored care, and the primary care setting: Possible solutions to reduce racial/ethnic disparities in mental health care. *Journal of Mental Health Counseling*, *36*(2), 173-188. https://doi.org/10.17744/mehc.36.2.d73h217l81tg6uv3

Lasalvia, A., Ventriglio, A., Colizzi, M., & Bellomo, A. (2019). Stigma as the main obstacle in health care and human rights among people with mental disorders. A rights-based ethics approach, 133-153. https://doi.org/10.3280/rsf2019-003006

Lê Cook, B., Doksum, T., Chen, C. N., Carle, A., & Alegría, M. (2013). The role of provider supply and organization in reducing racial/ethnic disparities in mental health care in the US. *Social Science & Medicine*, *84*, 102-109. https://doi.org/10.1016/j.socscimed.2013.02.006

Leong, F. T., & Kalibatseva, Z. (2011, March). Cross-cultural barriers to mental health services in the United States. In *Cerebrum: the Dana forum on brain science* (Vol. 2011). Dana Foundation.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage.

Logan, J. R. & Oaklev, D. (2017). Black lives and policing: The larger context of ghettoization. *Journal of Urban Affairs, 39*(8), 1031-1046. https://doi-org/10.1080/07352166.2017.1328977

Logan, J. R., Zhang, W., & Chunyu, M. D. (2015). Emergent Ghettos: Black neighborhoods in New York and Chicago, 1880–1940. American Journal of Sociology, 120(4), 1055–1094. https://doi-org/10.1086/680680

Lukyanova, V. V., Balcazar, F. E., Oberoi, A. K., & Suarez-Balcazar, Y. (2014). Employment outcomes among African Americans and Whites with mental illness. Work: Journal of Prevention, Assessment & Rehabilitation, 48(3), 319–328. https://doi.org/10.3233/wor-131788

Massey, D. S. (2016). *Segregation and the perpetuation of disadvantage*. New York, NY: Oxford University Press. http://dx.doi.org/10.1093/oxfordhb/9780199914050.013.17

Massey, D. S., & Eggers, M. L. (1990). The ecology of inequality: Minorities and the concentration of poverty. *The American Journal of Sociology,* 95(5), 1153-1188. https://doi.org/10.1086/229425

Maio, G. R., & Haddock, G. (2010). The psychology of attitudes and attitude change. Thousand Oaks, CA: Sage Publications. http://dx.doi.org/10.4135/9781446214299

McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: Policy implications. *Health Affairs*, *27*(2), 393-403. https://doi.org/10.1377/hlthaff.27.2.393

Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation*. John Wiley & Sons.

Morse, J. M. (2000). Determining Sample Size. Qualitative Health Research, 10(1), 3–5. https://doi.org/10.1177/104973200129118183

Mondi, C. F., Reynolds, A. J., & Ou, S.-R. (2017). Predictors of depressive symptoms in emerging adulthood in a low-income urban cohort. Journal of Applied Developmental Psychology, 50, 45–59. https://doi.org/10.1016/j.appdev.2017.03.009

Nikulina, V., Widom, C. S., & Czaja, S. (2011). The role of childhood neglect and childhood poverty in predicting mental health, academic achievement and crime in adulthood. *American Journal of Community Psychology*, 48(3-4), 309-321. https://doi.org/10.1007/s10464-010-9385-y

Noel, D. L. (1968). A theory of the origin of ethnic stratification. Social problems - SOC PROBL. 16. 157-172. https://doi.org/10.1525/sp.1968.16.2.03a00030

Novara, M., Loury, A., & Khare, A. (2017). The cost of segregation. Metropolitan Planning Council. Retrieved from https://www.metroplanning.org/work/project/33

Nusslock, R., & Miller, G. E. (2016). Early-life adversity and physical and emotional health across the lifespan: A neuroimmune network hypothesis. *Biological Psychiatry, 80*(1), 23–32. https://doi.org/10.1016/j.biopsych.2015.05.017

O'reilly, M., & Parker, N. (2013). 'Unsatisfactory Saturation': a critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative research*, 13(2), 190-197. https://doi.org/10.1177/1468794112446106

Owens, A., & Clampet-Lundquist, S. (2017). Housing mobility and the intergenerational durability of neighborhood poverty. *Journal of Urban Affairs*, *39*(3), 400-420. https://doi.org/10.1080/07352166.2016.1245083

Pascoe, J. M., Wood, D. L., Duffee, J. H., Kuo, A., & Committee on Psychosocial Aspects of Child and Family Health. Mediators and adverse effects of child poverty in the United States. *Pediatrics*, *137*(4), e20160340. https://doi.org/10.1542/peds.2016-0340

Perry, W. G., Jr. (1970). *Forms of intellectual and ethical development in the college years: A scheme.* New York, NY: Holt, Rinehart, & Winston.

Piston, S. (2018). Class attitudes in America: Sympathy for the poor, resentment of the rich, and political implications. Cambridge University Press.

Proctor, B. D., Semega, J. L., & Kollar, M. A. (2016). Income and poverty in the United States: 2015. *US Census Bureau, Current Population Reports*, P60-256.

https://doi.org/10.4135/9781506333496.n39

Quillian, L. (2012). Segregation and poverty concentration: The role of three segregations. *American Sociological Review*, 77(3), 354-379. https://doi.org/10.1177/0003122412447793

Quinn, M. (2018). Mental break-down. Retrieved from https://www.governing.com/topics/health-human-services/gov-chicago-mental-health.html

Rankin, B. H., & Quane, J. M. (2000). Neighborhood poverty and the social isolation of inner-city African American families. *Social forces*, *79*(1), 139-164. https://doi.org/10.1093/sf/79.1.139

Ravitch, S. M., & Mittenfelner Carl, N. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological.* Thousand Oaks, CA: Sage Publications, Inc.

Read, J., & Bentall, R. P. (2012). Negative childhood experiences and mental health: theoretical, clinical and primary prevention implications. *The British Journal of Psychiatry*, *200*(2), 89-91. https://doi.org/10.1192/bjp.bp.111.096727

Reddick, R. J., Welton, A. D., Alsandor, D. J., Denyszyn, J. L., & Platt, C. S. (2011). Stories of success: High minority, high poverty public school graduate narratives on accessing higher education. *Journal of Advanced Academics*, 22(4), 594-618. https://doi.org/10.1177/1932202X11414133

Reeves, R., Rodrigue, E., & Kneebone, E. (2016). Five evils: Multidimensional poverty and race in America. *Economic Studies at Brookings Report*.

Reiss, F., Meyrose, A. K., Otto, C., Lampert, T., Klasen, F., & Ravens-Sieberer, U. (2019). Socioeconomic status, stressful life situations and mental health problems in children and adolescents: Results of the German BELLA cohort-study. *PLoS one*, *14*(3). https://doi.org/10.1371/journal.pone.0213700

Santiago, C. D., Kaltman, S., & Miranda, J. (2013). Poverty and mental health: How do low-income adults and children fare in psychotherapy? *Journal of Clinical Psychology*, 69(2), 115-126. https://doi.org/10.1002/jclp.21951

Scharff, D. P., Mathews, K. J., Jackson, P., Hoffsuemmer, J., Martin, E., & Edwards, D. (2010). More than Tuskegee: understanding mistrust about research participation. *Journal of health care for the poor and underserved*, 21(3), 879–897. https://doi.org/doi:10.1353/hpu.0.0323

Schomerus, G., Matschinger, H., & Angermeyer, M. C. (2014). Causal beliefs of the public and social acceptance of persons with mental illness: a comparative analysis of schizophrenia, depression and alcohol dependence. *Psychological medicine*, *44*(2), 303-314. https://doi.org/10.1017/s003329171300072x

Sharkey, P., & Elwert, F. (2011). The legacy of disadvantage: Multigenerational neighborhood effects on cognitive ability. American Journal of Sociology, 116(6), 1934–1981. https://doi-org/10.1086/660009

Sohail, Z., Bailey, R. K., & Richie, W. D. (2014). Misconceptions of depression in African-Americans. *Frontiers in psychiatry*, 5, 65. https://doi-org/10.3389/fpsyt.2014.00065

Smith, M. S., Lawrence, V., Sadler, E., & Easter, A. (2019). Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK. *BMJ open*, *9*(1). https://doi.org/10.1136/bmjopen-2018-024803

Tomaskovic-Devey, D. (2019). *Poverty and social welfare in the United States*. Routledge. https://doi.org/10.4324/9780429302787-1

U.S. Census Bureau (2015). Government assistance participants. *Selected housing characteristics, 2007-2011 American Community Survey 5-year estimates*. Retrieved from: https://www.census.gov/newsroom/press-releases/2015/cb15-

Voisin, D. R., Elsaesser, C., Kim, D. H., Patel, S., & Cantara, A. (2016). The relationship between family stress and behavioral health among African American adolescents. Journal of Child and Family Studies, 25(7), 2201–2210. https://doi.org/10.1007/s10826-016-0402-0

Wadsworth, M. E. (2015). Development of maladaptive coping: A functional adaptation to chronic, uncontrollable stress. *Child Development Perspectives, 9*(2), 96–100. https://doi.org/10.1111/cdep.12112

Ward, E. C., & Heidrich, S. M. (2009). African American women's beliefs about mental illness, stigma, and preferred coping behaviors. *Research in Nursing & Health*, 32(5), 480–492. https://doi.org/10.1002/nur.20344

Ward, E. C., Mengesha, M., & Issa, F. (2014). Older African American women's lived experiences with depression and coping behaviors. *Journal of Psychiatric and Mental Health Nursing,* 21(1), 46–59. https://doi.org/10.1111/jpm.12046

Ward, E. C., Wiltshire, J. C., Detry, M. A., & Brown, R. L. (2013). African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. *Nursing Research*, 62(3), 185-194. https://doi.org/10.1097/NNR.0b013e31827bf533

Watson, A. C., & Wood, J. D. (2017). Everyday police work during mental health encounters: A study of call resolutions in Chicago and their implications for diversion. Behavioral Sciences & the Law, 35(5–6), 442–455. https://doi.org/10.1002/bsl.2324

Weiner, B. (1985). An attributional theory of achievement motivation and emotion. *Psychological review*, *92*(4), 548. https://doi.org/10.1037/0033-295x.92.4.548

Werth, E. (2013). The unfinished business of fair housing. Retrieved from http://theshriverbrief.org/2013/06/articles/housing-justice/the-unfinished-business-of-fair-housing/

Zwickert, K., & Rieger, E. (2013). Stigmatizing attitudes towards individuals with anorexia nervosa: an investigation of attribution theory. *Journal of Eating Disorders*, *1*(1), 5. https://doi.org/10.1186/2050-2974-1-5

Appendix A: Initial Questionnaire

Instructions

Please complete all fields of the questionnaire below to the best of your knowledge. This questionnaire is confidential and will be disposed of within six months of the research being fully completed.

Participant #_____

1. What is your age range?
    a. 18-24
    b. 25-45
    c. 46-65
2. What is your race? _____
3. How long have you lived in inner-city Chicago?
    a. None
    b. 0-5 years
    c. 6-10 years
    d. 10 years or more
4. How many of your family generations have lived in inner-city Chicago?
    a. None
    b. One generation (just you and your children live in inner-city Chicago)
    c. Two generations (my parent(s) also live(d) in inner-city Chicago)
    d. Three generations (my parent(s) AND my grandparent(s) also live(d) in inner-city Chicago
    e. Three or more generations
5. Have you been previously diagnosed with a mental health disorder or experienced severe stress and depression
    a. Yes
    b. No
    c. Not sure

6. How long have you experienced a reluctant attitude (if applicable) toward seeking professional mental health treatment?
    a. none
    b. 0-5 years
    c. 6-10 years
    d. 10 years or more
7. How many of your family generations have experienced a reluctant attitude toward seeking professional mental health treatment?

a. None or uncertain
b. One generation (just you and your children have experienced a reluctant attitude)
c. Two generations (my parent(s) also have experienced a reluctant attitude)
d. Three generations (my parent(s) AND my grandparent(s) also have experienced a reluctant attitude
e. Three or more generations

8. What is your highest level of education attained?
    a. elementary school
    b. high school
    c. associate's degree or vocational training
    d. bachelor's degree
    e. master's degree
    f. doctoral degree

9. How many of your family generations have experienced living below the poverty line?
    a. None
    b. One generation (just you and your children have lived below the poverty line in inner-city Chicago)
    c. Two generations (my parent(s) also live(d) below the poverty line in inner-city Chicago)
    d. Three generations (my parent(s) AND my grandparent(s) also live(d) below the poverty line in inner-city Chicago
    e. Three or more generations

Appendix B: Interview Questions

1. How would you describe the challenges you face while living in poverty in inner-city Chicago?
2. Tell me about your attitude towards mental health treatment?
3. Tell me about any personal experiences that contributed to your attitude towards mental health treatment?
4. How have you witnessed your family handling mental health issues (if any)? Did they seek mental health treatment, if needed?
5. What have you learned from your family members about mental health treatments?
6. In your opinion, what role do you think generational poverty has played in your family's mental health?
7. Tell me the role you think generational poverty has played in your personal mental health?
8. Tell me about the steps you take to safeguard your own mental health?
9. What do you feel about the type of help you get from mental health providers?
10. In your opinion, what are the reasons for the lack of access to mental health treatment?
11. Tell me about any attitudes toward mental health treatment that your maternal/paternal parent's shared with you.
12. Do you think mental health providers would provide you with adequate support when seeking mental health treatment?

13. Tell me about your perception of mental health care providers in inner-city Chicago.
14. In your opinion, what role do you think your community plays in your attitude towards mental health treatment?
15. What changes in the mental health experience could be made that would make you more inclined to seek treatment?