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Social Worker Perspectives of Working With Aging African Americans With Depressive Disorders

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This is to certify that the doctoral study by

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Walden University
2023

Abstract

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by

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MSW, Loma Linda University, 2010

BS, La Sierra University, 2007

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Although there is a greater proportion of people living with depressive disorders within the African American older adult population compared to their White counterparts, fewer African Americans are engaging in mental health treatment when compared to the Caucasian community. The purpose of this qualitative study was to explore the experiences and practices of social workers who are providing mental health care treatment to African American older adult patients (aged 65 and over) living with a depressive disorder. The study was framed using both the health belief model and critical race theory. To address the research questions, a generic qualitative design was used, incorporating semistructured interviews to explore the experiences and perspectives of seven social work practitioners providing care to African American older adult patients experiencing depressive disorders. Thematic analysis was used to analyze and reveal themes in the data. Findings revealed social workers can address issues of distrust, low autonomy, low engagement, and the resultant low participation and poor outcomes by prioritizing the development of trusting therapeutic relationships using conversational treatment plans to develop relationships over time, while minimizing defensiveness due to preconceived notions of stigma. Providing greater opportunities for engagement is critical to achieving positive outcomes. Program changes and educational opportunities to reduce stigma and support cultural awareness, both for therapists and clients, may help positive social change by affecting attitudes around mental health services and participation.

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Dedication

This capstone project is dedicated to the memory of my dear father Urie Waite. Not only was he my inspiration to research to this topic, but his memory has also been my motivation to complete it.

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I would like to acknowledge and sincerely thank my committee chairperson Professor Dorothy Scotten, who made this journey possible. Her patience, guidance, and advice carried me through all the stages of this process and served as a beacon of hope during moments of uncertainty. I would also like to thank my committee members for their directions and advice that too made this possible

I would also like to give special thanks to my two sons; Carsten and Jackson, who remained patient with me throughout this process. I love you both dearly and am eternally grateful for the opportunity to be your mother.

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Section 1: Foundation of the Study and Literature Review

Introduction

The reported prevalence of depressive disorders within the African American older adult population varies greatly from 6-33% (Cobb et al., 2020; Fowers & Wan, 2020; Hays & Lincoln, 2017; Hooker et al., 2019; Joshi et al., 2016; Novacek et al., 2020; Vinson et al.,2014), showing inconsistencies in estimations. The older adult population in the United States is comprised of 8.3% African Americans, with the expectation of a 2.7% increase by the year 2050 (Vinson et al., 2014). It is projected that there will be a 120% increase in mental health needs among aging African Americans between 2008 and 2030 (Vinson et al., 2014) possibly due to population increases, potential for increased life expectancy, and advanced identification of mental health issues among African American populations. Without a resolution, depressive disorders among the African American older adult population could negatively impact other areas of their health, such as a reduction in the quality of life, increased mortality, a decline in cognitive ability, and suicide (Joshi et al., 2016).

In Atlanta, social workers have an opportunity to work with the older adult population (aged 65 and over) in various settings. As a geriatric social worker and a gerontologist, I have had the opportunity to work with this group and observe the disparity in the retention and outcomes among African American seniors and Caucasian seniors in mental health treatment. Research shows that 26.8% of the Black population in the United States is affected by major depression (Rankin, 2016). In 2012, it was estimated that 815,000 older African Americans had diagnoses of severe mental illness, which includes major depression (Hays & Lincoln, 2017). Disparities in diagnosis and treatment of depressive disorders (in terms of late diagnosis and untreated symptoms) primarily due to cultural and historic factors and discriminatory practices are well documented, with symptoms more prevalent among the African American population (Cobb et al., 2020). The social determinants of mental health, including discrimination and implicit bias, all serve to perpetuate mental health inequities (Shim et al.,2018). In addition, depressive symptoms among older populations are often chronic and debilitating (Cobb et al., 2020). According to the Health Outcome Survey, 16% of older African Americans, compared to 9% of their non-Hispanic White counterparts, experienced depression (Hooker et al., 2019). At the same time, African Americans remain significantly less likely to receive treatment for depression compared to Whites (Hooker et al., 2019).

In addition, during the 2019 coronavirus disease (COVID-19) pandemic, the African American population experienced greater mental health needs than their White counterparts and are more likely to need mental health treatment in the future (Novacek et al., 2020). Some causes of depression and depressive disorders also can be linked to racism and police brutality; for example, significant increases in depression and anxiety were evident among African Americans after the death of George Floyd on May 25, 2020 (Fowers & Wan, 2020). Rates of depression went from 8% (Jan-June 2019) to 30% (May 28-June 2, 2020) and rates of anxiety during those same time periods rose from 8% to 34% among the Black population (Fowers & Wan, 2020).

Despite the prevalence of depressive disorders and other mental illness among the African American population, African Americans represent only a small fraction of those seeking mental health treatment (Helm, 2018). In addition, those who seek treatment are less likely to remain in treatment, to obtain proper treatment, or to find treatment options that meet the unique needs relating to culture and race (Kolivoski et al., 2014). The problem is that despite the fact that there are similar rates of people living with diagnosed depressive disorders within the African American older adult population compared to the White older adult population (estimated 6% of the population), fewer African Americans are retained in mental health treatment, with poorer outcomes, when compared to the Caucasian population (Conner et al., 2010; Davis et al., 2015; Huffman, 2020; Substance Abuse and Mental Health Services Administration [SAMHSA], 2020; Taha et al., 2015).

In this first section I provide a discussion and understanding of the problem and purpose of the study, the nature of the study, the significance of the study to the field of social work, the conceptual framework that informs and frames the study, and values and ethical principles applied to the study. Lastly, I provide a thorough review of the academic and professional literature surrounding the topic of interest.

The first section presents an introduction and overview of the study. This is followed by Section 2, which details the methodological aspects of the study. Section 3 includes the findings of the analysis of the data collected. Lastly, Sections 4 and 5 present practical implications of the research.

Problem Statement

African Americans represent only a small fraction of those seeking mental health treatment, despite the prevalence of mental illness, especially depressive disorders, among the population (Helm, 2018). Among African Americans who do seek treatment, outcomes remain poor as they are less likely to remain in treatment, to obtain proper treatment, or to find treatment options that meet the unique needs relating to culture and race (Kolivoski et al., 2014). Current research is clear on the prevalence of depression and depressive disorders in the African American community, the limitations, and biases from the perspective of the African American community. Continued research has remained unclear as to racial differences in trajectory of late-life symptoms of depression, while also noting increased risk estimates and odds ratios for depression by racial categories, including an increased risk among African American populations (Chang et al., 2016; Hooker et al., 2018). Rates of depressive disorders among older African Americans remain difficult to assess, as results have varied widely across samples when comparing to other racial and ethnic groups (Akinyemi et al., 2018). However, African Americans, despite the rates and risks for depression and depressive disorders, are significantly less likely to seek out, participate in, and remain in mental health services compared to their White counterparts (Conner et al., 2014; Huffman, 2020; SAMHSA, 2020).

Research evidence supports the need for mental health practitioners, both in general and particularly White American practitioners, to be more culturally aware (Vinson et al., 2014). After a thorough search, I was unable to find current research providing information on the perceptions and experiences of mental health professionals providing care to this group. Due to this disparity, I wanted to explore the experiences of social workers who are providing care to African American older adult patients (aged 65 and over) experiencing depressive disorders. Both social work practitioners and the African American older adult patients they serve may benefit from this study. The problem is that despite the significant proportion of people living with depression and depressive disorders within the African American older adult population, fewer African Americans are retained in mental health treatment and more have poorer outcomes, when compared to the White community (Conner et al., 2010; Davis et al., 2015; Huffman, 2020; SAMHSA, 2020; Taha et al., 2015).

Purpose Statement and Research Questions(s)

The purpose of this qualitative study was to explore the experiences and practices of social workers who are providing mental health care treatment to African American older adult patients (aged 65 and over) living with a depressive disorder. Although depression and depressive disorders in the African American older adult population continues to increase, there continues to be a low rate of treatment involvement and retention by this group, resulting in poorer outcomes (Huffman, 2020). A continuum of research, ranging from 2010 to 2020, has addressed this phenomenon by exploring barriers to treatment from perspectives such as medical disparities and racial barriers such as perceived stigma, distrust, and lack of cultural awareness (Conner et al., 2010; Davis et al., 2015; Huffman, 2020; Taha et al., 2015).

Research shows there are difficulties with retention in mental health treatment (i.e., keeping clients engaged in and compliant with treatment) and poorer outcomes among African Americans (Conner et al., 2010; Davis et al., 2015; Huffman, 2020; Taha et al., 2015). There was a gap in the research in terms of understanding the perspective of the social workers who are providing mental health treatment to this group, what their thoughts are as it relates to the lack of retention and poor treatment outcomes, and what changes can be made to practice that will support more effective treatment of the population of older African Americans. I addressed the following qualitative research questions in my study:

RQ1: What are the experiences, challenges, and perceived best practices among social work practitioners who are providing care to African American older adult patients diagnosed with depressive disorders?

RQ2: How do social work practitioners who are providing care to African American older adult patients diagnosed with depressive disorders describe their practices to improve retention and health outcomes among this population?

To address the gap in the research and the stated research questions, a generic qualitative design methodology was used. I used interviews to explore the experiences of social work practitioners providing care to African American older adult patients experiencing depressive disorders, and also their perspective on the small fraction of this population who are seeking treatment, the low treatment retention, and also low treatment outcomes, given the research evidence supporting these problems (see Connor et al., 2010; Davis et al., 2015; Huffman, 2020; Taha et al., 2015).

Nature of the Doctoral Project

The nature of this study was a generic qualitative study (see Kahlke, 2018; Patton, 2015). A generic qualitative research approach is appropriate for understanding social work practitioners' experiences and approach to care for the older adult African American population with depressive disorders, for whom there is a noted disparity between the prevalence of depression and depressive disorders and treatment outcomes. Generic qualitative research focuses on exploring the participants' perspectives on the issue being examined (Bellamy et al., 2016; Elliott & Timulak, 2021; Kahlke, 2018). This is done by inviting them to share their experiences, perceptions, and meaning derived from their provision of mental health care to treat depressive disorders among older adult African American populations, their participation in the therapeutic relationship, and their perception of challenges and best practices related to providing mental health care to this population (see Kahlke, 2014; Percy et al., 2015). The use of interviews to obtain information that was then analyzed to identify themes and presented as results are characteristics of the generic qualitative approach (see Mihas & Odum Institute, 2019; Patton, 2015; Percy et al., 2015). As the researcher, I used the generic qualitative inquiry as a research approach to collect information from practitioners, with the goal of improving the services offered to this population (see Patton, 2015).

Data for the study included seven interviews with a purposeful, convenience sample of social work practitioners in Georgia. Recruitment criteria included (a) must have a degree in social work, (b) must be working with African American older adult patients with a documented diagnosis of depression or depressive disorders (can have co-occurring disorders, but depression must be diagnosed and documented as one disorder), and (c) must have a minimum of 3 years of experience in the field. Participants were recruited from a Georgia area geriatric mental health professionals group on Facebook, and also from an emailing to all licensed Georgia social work practitioners. The geographic area was limited to the State of Georgia for the purposes of consistency, and proximity to the researcher to reduce associated costs for the research. A flyer was posted on the Facebook group page and via email to all Georgia social worker practitioners. Potential participants were asked to contact me via email.

The sample size of seven participants aligned with the anticipated availability of participants and the recommendations for specific sample sizes in qualitative research. Qualitative research typically incorporates smaller sample sizes, in contrast to the relatively large sample sizes recommended to support validity in quantitative research (Cobern & Adams, 2020). Cobern and Adams (2020) contended that the researcher’s judgement comes into play when trying to approximate when saturation of the data may occur to attempt to estimate a needed qualitative sample size but supported a general recommendation of between 10-20 interviews.

The data were qualitative, collected from interviews (see Cobern & Adams, 2020). As the researcher, I developed eight semistructured interview questions designed to support an in-depth understanding of the perspective of the social workers who are providing mental health treatment to older adult African American patients their thoughts related to the lack of involvement and poor treatment outcomes, and what changes can be made to practice that will support more treating and retaining the population of older

African Americans. Therefore, the relevant data obtained from the interview discussion were analyzed for themes across all participants. All collected data were reviewed for relevance to the topic and theme generation using thematic analysis, an approach selected because provided me with tools and strategy for conducting, organizing, and interpreting the qualitative data analysis toward creating a narrative understanding that will highlight commonalities and differences in the participant responses (see Crowe et al., n.d.). I used the six-step process for conducting thematic analysis offered by Nowell et al. (2017) supporting trustworthiness criteria as outlined by Lincoln and Guba (1985).

Potential barriers included sampling bias, cultural bias, and ensuring a clear separation of my role as a geriatric therapist from my role as a researcher, which was a challenge. Due to the presence of the global COVID-19 pandemic, recruitment also was challenging, as social workers may have faced loss of jobs due to companies going out of business or reducing staff, or may have been overwhelmed with the need to care for themselves, while caring for their patients. Patients may have increased needs created by the pandemic, leaving social workers potentially hesitant to participate in anything beyond their work responsibilities. To address this challenge, participants were given the informed consent form prior to participation, which detailed their rights and specifically state that potential participants freely can choose to withdraw at any time from the study without negatively impacting the research.

Significance of the Study

This study was significant in that the results of this research may fill a gap in understanding the limited use of mental health treatment within the African American older adult population, through the lens of the social work practitioners who are providing care to this group. Knowledge from this perspective may result in increased retention of this group in treatment, supporting more positive outcomes. This project was unique because the focus was on the practitioners' experience, challenges, and perceived best practices, rather than directly on the experiences of the African American population. This study served to bring attention to the experience of the mental health practitioners who are serving this group, and any barriers they might identify. Taking this approach may increase the retention of the African American older adult population in mental health treatment, resulting in better quality of life for those in this group who are living with depression.

Theoretical and Conceptual Frameworks

When examining the disparity in mental health treatment among the African American older adult population, race emerges as a main factor (Kolivoski et al., 2014), particularly in relation to health behavior. Race has also been labeled a risk factor for mental illness, leaving the African American older adult population more susceptible (Reynolds & Gonzales, 2017). Current research has identified insufficient culturally competent social work practitioners as a major barrier to mental health treatment for the African American older adult population (Nguyen et al., 2021; Shellman et al., 2011). To better understand this issue, I incorporated two frameworks for this study, a theoretical framework of critical race theory (CRT) and a conceptual framework based on the health belief model (HBM) to better understand and frame the findings of social workers treating older adult African Americans with depressive disorders.

The HBM was one of the early models of health behavior and remains one of the most frequently used models today (Butts & Rich, 2018). HBM was developed in the 1950s by a group of United States public service social psychologists who sought to understand why people did not participate in screening services to prevent and detect diseases (Butts & Rich, 2018). HBM was the first model to help explain and predict health behavior (Louis, 2019), focusing on individuals' attitudes and beliefs that support their actions toward their own health (Abraham & Sheeran, 2005). The model consists of six constructs that are thought to influence an individual's decision to engage in prevention, control, or screening for disease: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cue to action, and self-efficacy (Butts & Rich, 2018). In this study, I used the HBM to build a framework to describe and drive potential clinical tools and best practices in addressing retention and treatment outcomes among African American older adult clients receiving treatment for depressive disorders.

In addition, the findings of the study were explored within the context of CRT, which emerged in the late 1960s to refuel the issues of the civil rights movement (see Delgado & Stefancic, 2007). Delgado and other law professors presented this theory as a lens through which to view the world. Racism was presented as a natural part of African Americans' everyday life, embedded in society's fabric for power and control (Delgado & Stefancic, 2007). The premise of the CRT is that policies and power structures are being used to create and maintain racial inequalities (Kolivoski, et al., 2014). Through the lens provided by CRT, not only does the impact of race result in inequalities by empowering the White race, it further creates impenetrable social barriers for minorities, by influencing the very outlets needed to assist them (Coxshall, 2020). An example of this can be seen in the continued use of the Geriatric Depression Scale, a tool that is widely used by geriatric social workers in the assessment of depressive disorders in older patients. Research has shown that this tool lacks cultural sensitivity, and strengthens already existing disparities (Vinson et al., 2014). Social workers are the primary source of mental health treatment for people living with depressive disorders (Kolivoski et al., 2014). With a primary focus on treatment at the individual level during their academic training, social workers "may not have opportunities to fully develop skills necessary to assess the role of race, racism, and power in their practice and work environment," (Kolivoski et al., 2014, p. 273, para. 5). Within the context of CRT and the role of social workers in providing mental health treatment, education and training to support the necessary skills, sensitivity, and cultural competency is critical.

Bussey et al. (2022) identified social work as a profession in which social justice is an ethical mandate, and which is poised to lead systems change toward greater equity through supporting intentional anti-racist practice and consciousness-raising efforts. The authors highlighted the importance of embedding CRT in research on social work practice, such as the present study, by identifying the need for social worker training on "how to identify, name and disrupt oppressive practices" (Bussey et al., 2022, p. 907). In addition, according to Bussey et al., given the growing polarization and bigotry evident in society, this type of training is even more critical. Bussey et al. offered an outline for customizable antiracist and antibias training for various social work practices in the United States, develop and bult upon unconscious bias core training and drawing connections between systemic oppressive structures, historical evidence, maintenance of the dominant narratives, and microlevel bias. These factors contribute to the disparate experiences and outcomes for African Americans and communities (Bussey et al., 2022). Lastly, the authors supported the benefit to social workers in terms of developing their ability to reflect upon their own role in the perpetuation of racism and bias in social work settings and beyond.

Data collected in this study was used to explore the practices and assessment tools used by the social worker participants and what practices are felt to be effective or ineffective for addressing depressive disorders among the older adult, African American population. The results, framed within the context of CRT may help understand mental health retention or lack thereof, and key focus areas to support social change. Combining CRT with the HBM provided a comprehensive framework within which to explore the experiences and perceptions of social workers, and how to potentially address issues surrounding treatment retention and outcome disparities in depressive disorders among older adult African American populations.

When applied to understanding the experiences of social workers treating older adult African Americans experiencing depressive disorders, the principles of the CRt and HBM were used as a backdrop to examine the impact of the training and tools being used by mental health professionals to support the mental wellbeing of the African American older adult population, and how these tools are thought to affect their experience while in treatment and the decision to remain in treatment (see Conner et al., 2010). Due to the impact of racism, discrimination, and poverty, African Americans suffer from more mental health challenges than their White counterparts and use mental health services less (Conner et al., 2010). According to CRT, understanding these dynamics of racism, discrimination, and poverty is critical to achieving effective mental health treatment (Kolivoski et al., 2014). In addition, clinicians can use HBM to support and potentially address the older adult African American population perceptions of susceptibility, severity, benefits, and barriers to seeking and remaining in treatment, with better understanding of how to support a move toward a cue to action, and self-efficacy among the older adult African American population with depression (Butts & Rich, 2018). Using these theories helped me to understand the experiences and perceptions of the practitioners that may impact the beliefs, attitudes, and behaviors of the population of older adult African Americans with depressive disorders, and to know if there are identified unmet needs for the practitioner contributing to the mental health disparity for this group.

Values and Ethics

For this study, several relevant values of the code of ethics applied. First, the value of social justice was applicable such that social workers challenge social injustice. By definition, “Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people” (National Association of Social Work [NASW], Code of Ethics, 2021). In this study, I sought to support positive social change through understanding the experiences of clinicians treating African American older adult populations within the context of the identified mental health care disparities for this population, notably, disparities in treatment and treatment retention among clients with depressive disorders. In doing so, I hoped to support greater knowledge and an appropriate sensitivity to cultural and ethnic diversity, as specified in the code of ethics (see NASW Code of Ethics, 2021). The second value relevant to this study was competence. The associated ethical principle is that social workers seek to practice within their level of competence while developing and enhancing their expertise (NASW Code of Ethics, 2008). As a social worker, I seek to enhance the practice of other social workers as well as my own through gaining knowledge specific to the experiences of this vulnerable and underserved population.

The clinical social work problem I explored in this study was the experience of social work practitioners who are providing care to the Africa American older adult population experiencing a depressive disorder. This was explored because, despite the fact that there is a greater proportion of people living with depressive disorders within the African American older adult population compared to their White counterparts, fewer African Americans are engaged and retained in mental health treatment when compared to the Caucasian community (see Conner et al., 2010; Huffman, 2020). Current research suggests that reasons for this disparity include challenges with access to care, discrimination embedded in treatment options, and also the lack of culturally competent practitioners (Conner et al., 2014; Davis et al., 2015; Huffman, 2020; Taha et al., 2015). The relevant NASW Code of ethics values applicable to this social work problem are social justice and competence. The ethical principle attached to the social justice value implies that social workers should be actively engaged in efforts that addresses practices that leaves any marginalized group at further disadvantage. This value also points to the need for culturally competent practitioners among those serving this group. This point is further reiterated by the ethical principle attached to the value of competence, which admonishes the social work practitioner to work towards competency in their area of practice.

Review of the Professional and Academic Literature

The problem addressed herein is that despite the greater proportion of people living with depressive disorders within the African American older adult population compared to their White counterparts, fewer African Americans are engaged and retained in mental health treatment when compared to the White community (see Connor et al., 2010; Davis et al., 2015; Huffman, 2020; Taha et al., 2015). Therefore, the purpose of this qualitative study was to explore the experiences and practices of social workers who are providing mental health care treatment to African American older adult patients (aged 65 and over) living with a depressive disorder. Despite continuous increases in depressive disorders among the African American older adult population, there continues to be a low rate of treatment retention by this group. I addressed this phenomenon by exploring barriers to treatment from perspectives of medical disparities and racial barriers such as perceived stigma, distrust, and lack of cultural awareness (see Conner et al., 2010; Davis et al., 2015; Huffman, 2020; Taha et al., 2015). In this review, I explored CRT and the HBM, as well as factors that may impact treatment participation and retention, as well as associated mental health outcomes.

Several research databases were searched for relevant literature used to build the literature review. These databases included Google Scholar, ScienceDirect, SocINDEX, PsycINFO, and ProQuest. As the researcher, I conducted an exhaustive search for relevant, peer-reviewed literature, with a focus on literature published within the last 5 years, but also inclusive of related seminal research, both generally and related to the conceptual/theoretical framework. Walden University dissertations and theses also were searched and utilized where appropriate.

Research articles were located using keyword searches. The keywords searched included *depression and African American Older adults, mental health and the African American culture, African Americans, social work, therapy, counseling, depression therapy, critical race theory, social work practice and African Americans, cultural competence, medical mistrust, patient-provider relationship, depression and African American Geriatrics,* and *depression therapy and racial discrimination*. Various combinations of these key terms were used in searching the databases for relevant literature.

This review provides information not only on the background of mental health within the African American community and the barriers to engagement an retention in mental health treatment from the perspective of the African American community, but also on the options most often used within the African American community and best practices for clinicians to provide more culturally appropriate treatment options.

Critical Race Theory

The premise of CRT, as noted previously, is that social policies and power structures are being used to support and uphold racial inequalities (Delgado & Stefancic, 2007; Kolivoski et al., 2014). Through the lens of CRT, inequalities arise by empowerment of the white race while simultaneously creating impenetrable social barriers for minorities (Coxshall, 2020). Blum (2019) asserted the term "racism" has evolved into a more powerful and broad concept, with social and institutional racism highlighted when discussing race relations in the United States. According to Blum:

> [Social racism] comprises racist beliefs, attitudes, and stereotypes widely shared within a given population and expressed in cultural and social modes such as religion, popular entertainment, advertisements and other media. Institutionalized racism refers to racial interiorizing or antipathy perpetuated by specific social institutions such as schools, corporations, hospitals, or the criminal justice system as a totality. (p. 5)

Thus, the term racism has expanded to include social and institutional racism and not only interpersonal racism.

CRT reveals how racism can be revealed in terminology suggestive of what is termed mainstream, normal, or neutral policies and practices (George, 2021). Indeed, CRT can be used as a framework from which to support theory and challenge existing ideas of race and racism and how these ideas impact social structures and practices, such as social work practice (George, 2021). Discrimination in the healthcare setting is a key contributing factor to disparities in health outcomes among African Americans (Mayus et al., 2017). Research supports the perpetuation of mental health disparities stemming from discrimination and implicit bias linked to the social determinants of mental health, suggesting that providers expand their roles as advocates for social change and inclusion to support a reduction and ultimately the elimination of mental health inequities (Shim et al., 2018).

Kolivoski et al. (2014) contended that despite acknowledgement of racial disparities and racism in social work and addressing social problems, the profession as a whole has failed to fully incorporate critical race theory. The authors provided a discussion of CRT and the alignment of CRT with social work field in terms of mission and values, particularly within the tenets of child welfare, public assistance, and mental health, supporting the incorporation of CRT as a conceptual framework for this study and for social work practice in general.

Development of a CRT model represents an effective way to deal with racialized conditions using historical, narrative and social change contexts (Taylor, 2000). Aligning with CRT, racism is seen as ingrained in the culture, continuously oppressing and marginalizing populations while White privilege is normalized to people’s understanding of the world and ourselves in the world. The notion of “racism as normal” can be explained with the idea that while most Whites deny being racist, most also cannot reasonably say they have avoided the privileges of being White. “They see themselves as good and fair people, and neglect to acknowledge they live as members of a group that enjoys certain privileges” (Taylor, 2000, p. 548), thus, denying racism.

According to Teasley et al. (2021), racism must be differentiated from individual acts of bigotry and prejudice, because:

> Racism is different from racial prejudice, hatred, or discrimination. Racism involves one group having the power to carry out systematic discrimination

> through the institutional policies and practices of the society and by shaping the cultural beliefs and values that support those racist policies and practices. (Dismantling Racism Works [n.d.], as cited in Teasley et al., 2021)

Social work practice is not beyond these racist policies and practices. Indeed, the history, development, and current state of social work are interdependent, and reveal that white supremacy lies within the foundation of social work practice, education, research, and advocacy, as it is within the foundation of U.S. history (Almeida et al., 2019). For example, initial social work practice in the United States was based on the distribution of social welfare by what was perceived as deserving with non-Whites deemed less deserving (Almeida et al., 2019). In fact, most charity organizations in the 19th century were racially segregated and primarily created for White individuals, lacking any challenge to systemic racism and/or norms (Gregory, 2021). Thus, research has contended that social work is rooted in “white logic and white methods” (Bonilla-Silva & Zuberi, 2008, p. 4). Although all professions are situated within their larger societal context, social work as a discipline uniquely has an obligation to challenge social injustice. Bussey et al. (2022) supported the notion of social justice as a professional ethical mandate in social work, and as such, social work is poised to lead systems level change. To do this, social workers must be trained on how to identify, name, and disrupt oppressive practices.

Racial disparities are evident among older Black and Latin populations, who report higher rates of diabetes, hypertension, and obesity compared to Whites; however, older White populations report increased rates of cancer, lung disease, and heart disease compared to Black and Latin populations (Gonzales et al., 2021). When added up into a metric representing the rate of total chronic health conditions, older Black Americans have the highest rates of total chronic health conditions, which then affect disparities in other health areas, such as was seen with the COVID-19 pandemic (Gonzales et al., 2021). Thus, when considering a population of older adult African Americans, social workers must critically examine how CRT and its evolving landscape continues to shape racial inequities and health outcomes (Jenkins-Morales et al., 2022). Further, when considering racism in this context, the potential for the influence of systemic racism and resultant power imbalances within the therapeutic relationship is significant and justifies the inclusion of the CRT model in this study.

Health Belief Model

One of the early theories of health behavior, the HBM remains one of the most frequently used theories among health behavior researchers (Butts & Rich, 2018). The model was developed in the 1950s as a result of the failure of the tuberculosis screening program in the United States in an effort to understand participation and nonparticipation in medical screening services in general for the prevention and detection of diseases (Butts & Rich, 2018). HBM was the first model to help explain and predict health behavior (Louis, 2019) by focusing on individuals' attitudes and beliefs that support their actions toward their own health (Abraham & Sheeran, 2005). The model consists of six constructs that are thought to influence an individual's decision to engage in prevention, control, or screening for disease: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cue to action, and self-efficacy (Butts & Rich, 2018). As it applies to this study, clinicians can use HBM to support and potentially address the older adult African American population perceptions of susceptibility, severity, benefits, and barriers to seeking treatment, with better understanding of how to support a move toward a cue to action, and self-efficacy among the older adult African American population with depression (Butts & Rich, 2018). The HBM can be used to develop strategies to help patients understand the severity of depressive disorder (perceived severity), the barriers they may have to treatment and retention (perceived barriers), and that effective treatment options are available for older adult patients to improve quality of life (perceived benefits; Butts & Rich, 2018).

In a scoping analysis of the HBM, Sulat et al. (2018) noted that HBM variables were consistently related to behaviors, but that the strength of the correlation was varied across the studies explored. According to the authors, perceived barriers and perceived benefits were the strongest predictors and perceived severity was the weakest, while the association between the HBM variables and health behaviors was moderated by aspects of behavioral outcomes. This conclusion offered by Sulat et al. supports further research into the examination of the HBM variables in specific subgroups, such as African American geriatric mental health, using the model to inform a conceptual framework for the conclusions for this subgroup.

Treating Depressive Disorders among Older Adults

Depressive disorders are the most common mental disorders in old age and the diagnosis is associated with various negative health consequences for the affected individual (Stark et al., 2018). Depression later in life affects 15% to 20% of people older than 65 and is associated with a reduction in quality of life, individual function, and an increased risk of death (Lindblad et al., 2019). Symptoms of depression and depressive disorders include sadness, irritability, and other psychophysiological changes (Chang et al., 2018). Prevalence of depression at some point in individuals' lifetime is about 12% among older adults (those over the age of 60). Depressive disorders are associated with an increased risk of suicide and is the leading cause of disability (Chang et al., 2018). Older adults, with increased life expectancy and social changes common to older age, such as living alone, have a noted prevalence of psychological crises, a social problem that contributes to depression prevalence among this population (Bae & Kim, 2018). In a sample of 811 community-dwelling adults aged 60 and over who received paid home care during the 2008–2014 Health and Retirement Study, Xiang et al. (2018) found depression affected a substantial proportion of these older adults (one in two suffering from depression) and may be inappropriately treated, as the rate of receipt of medication or psychiatric treatment declined with age. These findings support the need for better understanding of and treatment for depressive disorders among older adults.

Research supports that with adequate care for populations of older adults suffering from depressive disorders there can be positive outcomes (Lamoureux-Lamarche et al., 2021). Laoureux-Lamarche et al. (2021) examined the association between adequacy of care and remission of common mental disorders, specifically depression and anxiety disorders, and the associated change in quality of life and life satisfaction among older adults. The study, conducted in Canada, explored care for depressive and anxiety disorders recorded among a sample of 225 older adults

(Lamoureux-Lamarche et al., 2021). Adequacy of care was based on Canadian guidelines and relevant literature. The authors measured depressive disorders and anxiety at baseline and follow-up, and remission was defined by absence of a baseline disorder at follow-up. Using a quality of life and satisfaction scale, the authors assessed quality of life and satisfaction with life at baseline and follow-up. Results of the study indicated that an estimated 40% of the older adults studied received adequate care for depressive and anxiety disorders, and notably, 55% were in remission at follow-up, supporting that adequate care is associated with remission, and improvement in both perceived quality of life and satisfaction with life (Lamoureux-Lamarche et al., 2021). These results highlight the importance of providing timely and adequate care for depressive disorders.

Other researchers have examined whether the patient perception toward healthcare providers differs between older adults with and older adults without clinical depression and whether this perception affects treatment among older adults with clinically significant depressive symptoms (see Nelson & Purtle, 2018). The participants included nearly 7,000 older adults (age 65 or older) in community living. According to Nelson and Purtle (2018), older adults with clinically significant depressive symptoms were more likely to have poor (or negative) perceptions of the quality of provider communication, and these odds were similar among those who received and did not receive mental health treatment. Understanding the perceptions of care among older adult patients with depressive symptoms, providers can incorporate more intensive communications strategies to ensure patients both feel heard by the provider and understand the care instructions given to them.

Research has suggested that the preconceptions of patients on depressive disorders has a significant impact on seeking and participating in treatment (Stark et al., 2018). Stark et al. (2018) collected qualitative data through semistructured interviews with a sample of 12 patients in primary care who were aged 75 years or more and who were diagnosed with depressive symptomology. Using content analysis, the results highlighted broad views related to depression and treatment of depressive disorders among the older adult sample (Stark et al., 2018). While some patients were well informed and well versed on depression and belief in efficacy of treatment options, others demonstrated related misconceptions (Stark et al., 2018). These findings further highlight the importance of understanding, education, and communication. Other themes indicated common concerns related to speaking about depression within social networks for fear of negative reactions and reports of little understanding and/or patience among others for their depression (Stark et al., 2018). Lastly, the perceived role of their primary care physician or general practitioner in treating depression was varied with some patients believing that the primary care provider had little relevance or role in the treatment of depression (Stark et al., 2018). The authors recommended improving management of depression among older adults through providing age-appropriate education to older adults about depression as a recognized medical disorder. This type of education would support better informed patients, less misconceptions, more confidence and comfort in discussing depression with care providers, family, and in other social settings.

The use of cognitive behavioral therapy (CBT) as a treatment option for older adults with depressive disorders has been shown to be effective (Choryan Bilrey et al., 2022). Choryan Bilrey et al. (2022) discussed the role of structured therapy techniques within CBT that are particularly useful in the treatment of depressive disorders in older adults, highlighting specific recommendations to support greater effectiveness of CBT with older adult clients. These included behavioral activation as a starting point for CBT, cognitive reappraisal for preventing future depressive symptoms and supporting long-term maintenance, and a lifeskills approach. Lifeskills approach was described as a new type of augmentation of CBT to achieve a more age-appropriate result in which the clinician is encouraged to identify and include prior successful coping strategies applied to challenges that have occurred over the lifetime of the older adult (Choryan Bilrey et al., 2022). With this approach, the practitioner is able to value how the older adult client has overcome adversity in the past and support a more positive narrative, away from failure and toward resilience and self-acceptance (Choryan Bilrey et al., 2022).

For older adults demonstrating some depressive disorders, collaborative care in primary care has shown effectiveness (Bonvoisin et al., 2020). The author noted a significance threshold of attending five sessions or more, supporting statistically different outcomes among intervention and control groups at this level of engagement (five sessions). Bonvoisin et al. (2020) concluded causal effectiveness of collaborative care in reducing depressive symptoms among older adults adhering to treatment plans, supporting a minimum effective treatment plan inclusive of five sessions. The results of the study by Bonvoisin et al. highlighting the threshold of five sessions provides critical information to care providers in terms of formulating an initial treatment target.

Although the major treatment options for depression include psychotherapy and antidepressants, older adults are at a higher risk of experiencing side effects of antidepressant medications, putting an emphasis on non-pharmacologic treatments for older adult patients (Chang et al., 2018; Frank, 2014; Pitychoutis et al., 2013). In addition, according to Lindblad et al. (2019), older patients often are slower to respond to antidepressants, antidepressants may not be effective with co-occurring dementia, and antidepressants are associated with fall risk among older patients. Other chronic illnesses are common among the older adult population, often limiting exercise and even mitigating the benefits of antidepressant medication (Lindblad et al., 2019). Cognitive behavioral therapy and exercise, two more common treatment options, have shown inconsistent improvement of depression among older adults. Other less common treatment options that have been shown to be effective for depression among older adults include light therapy (Chang et al., 2018), and omega-3-fatty acid treatments (Bae & Kim, 2018), although evidence for the benefits of these treatment options seems to be limited to mild to moderate depression in this population (Bae & Kim, 2018). Thus, treatment often focus on nonpharmacological options, with inconsistent outcomes within this older adult population.

Turning an eye to unique difficulties among nonwhite and minoritized older adults, Rawlings and Bains (2020) conducted a systematic review and thematic synthesis of qualitative research on older adults from black, Asian and minority ethnic communities, who were reported to be at an increased risk for depressive symptoms but remain underrepresented in healthcare services. The authors sought to use the qualitative research to better understand the experiences and management of depressive disorders by these older adults from specific racial and ethnic groups. A total of 12 research articles were included, which described depressive experiences of 210 older adults in North America, South America, and Asia. The study looked at the understanding of depression within the older adult minority groups, which showed general familiarity, but limited understanding of the term; socio-cultural norms related to managing depression among the groups, which suggested experiences were generally kept hidden and privately managed; and reported barriers to seeking treatment, particularly Western treatments for depression, although among those who did receive treatment, the participants reported value added in opportunities to share difficulties (Rawlings & Bains, 2020). Overall conclusions were that (a) the term depression was familiar, but not well understood; (b) perceived negative attitudes toward depression supported the dismissal of symptoms; (c) socio-cultural factors contributed to older adults managing depression in secret; (d) perceived value of psychotherapy among older adults as providing the opportunity to share their difficulties (Rawlings & Bains, 2020).

Treatment Retention in Mental Health Services among African Americans

Mental health concerns, such as depression, among older adults represent a major public health concern, often resulting in negative outcomes such as increased disability and mortality (Conner et al., 2014). Yet, among African Americans, less than 9% will seek mental health services (Huffman, 2020; Neighbors et al., 2008; Substance Abuse and Mental Health Services Administration [SAMHSA], 2020; CDC, 2013). Furthermore, among older adults, less than 3% seek professional mental health services for the treatment of depressive disorders (Conner et al., 2014). African Americans, despite similar rates of depression, are significantly less likely to seek out, participate in, and remain in mental health services compared to their White counterparts (Conner et al., 2014; Huffman, 2020; SAMHSA, 2020). In addition, chronic depressive disorders is much higher among African Americans at 56% compared to Caucasians at 38% (Bailey et al., 2019). Among those 56% of African Americans with chronic depressive disorders, less than half sought treatment, even though qualifying their disease condition as severe or disabling (Bailey et al., 2019).

According to Cobb et al. (2020), it is known that depression among underserved populations remains largely untreated, but factors related to receiving or not receiving treatment remain obscure. Cobb et al. sought to explore the social correlates of untreated depression among African American older adults in economically disadvantaged communities. A cross-sectional survey design was employed with a population of 740 African American older adults (defined as age 55 and over) in South Los Angeles, California. The study examined untreated depression in relation to various social and demographic variables. The results offered by Cobb et al. indicated factors serving to predict receiving treatment for depression, which included age, educational attainment, and number of providers (a variable designed as a measure of access to and use of care), although it was noted that the study did not include religious, or faith-based coping mechanisms.

Huffman (2020) reported the primary barriers to seeking mental health services among the African American community as stemming from a lack of resources and access to quality care, a lack of awareness, perceived stigma, and cultural distrust of the healthcare system. In addition, African Americans are more likely to perceive White clinicians as not trustworthy, lacking skills, lacking cultural awareness, and unable to connect with the client (Davis et al., 2015). Furthermore, African Americans prefer the use of more informal church support when facing mental health issues, relying on religious coping mechanisms. Thus, Black churches continue to be a resource for mental health services among African Americans, using coping dimensions of collaborative religious problem solving, deferring religious problem solving, and self-directed religious problem solving (Huffman, 2020). However, the ability of Black churches to meet their community's mental health needs seems unclear and needs additional research.

Huffman (2020) explored the underutilization of mental health services among African Americans stemming from social constructions of discrimination and other social determinants of health (Davis et al., 2015; Huffman, 2020; Shim et al., 2018) with a keen eye on religion as a potential barrier using a qualitative design incorporating semi-structured interviews with 12 African Americans who regularly attend a Black Church. The participants in the study described being worried about receiving formal mental health treatment due to the perceived stigma of being labeled with a mental health disorder/diagnosis. The participants also described feeling safer and more comfortable seeking psychological support from their church instead of from formal mental health services. The author provided three main findings: (a) Faith (religion) and perceived stigma support a reluctance in the African American participants to enter therapy and seek professional mental health treatment; (b) the African American participants would seek mental health services only as a last resort; and (c) the African American participants believed clergy should be trained to provide counseling, with clergy referring the person to mental health services only when they are not competent to provide the necessary mental health interventions (Huffman, 2020). From the results of the study, Huffman (2020) concluded there is a need to bridge the gap in psychological care provided by the church/clergy and mental health professionals.

Also, using a qualitative method, but with focus groups of 42 older African Americans who had recently reported a major depressive episode, Conner et al. (2014) found several themes that may help explain the disparities in health seeking behaviors among the population. First, the authors noted that while older African Americans could identify their symptoms and causes of their depression, they had difficulty recognizing their depression. Second, when recognized, they often failed to seek treatment for the depression in a timely fashion, delaying treatment until symptoms were more extreme. Third, participants described personal beliefs about depression and related treatment based on myth or untruths, serving as additional barriers to seeking treatment. Fourth, participants also described perceptions and experiences with stigma with high frequency, serving as a deterrent to seeking mental health treatment. Lastly, participants described engaging in culturally approved strategies to address their depression, such as community or faith-based practices.

Further, African Americans have been shown to be more likely to discontinue mental health care services (Taha et al, 2015) and substance abuse treatment (Davis et al., 2015) than their White counterparts for reasons such as the desire to deal with mental health issues on their own or feeling like it is not needed, as well as perceived discrimination (Davis et al., 2015; Taha et al., 2015). Davis et al. (2015) reported that African Americans were more likely to perceive White clinicians as not trustworthy, lacking skills, lacking cultural awareness, and unable to connect with the client. Other factors reported as barriers among African Americans in mental health care include lack of access to insurance coverage, lack of support from family and friends, low motivation, disbelief in the effectiveness of therapeutic treatment, and anxiety related to public transportation, risk of loss of parental rights, mental health stigma, and perceived weakness (Anyikwa, 2015; Cheng & Lo, 2015; Watson-Singleton et al., 2017). A significant reported barrier to retention among African Americans in mental health services is experiences of discrimination, which also has been shown to be related to symptoms of depression and poorer mental health outcomes among African-Americans (Cuevas et al., 2016; Hudson et al., 2016; Mayus et. al., 2017). This is particularly true as it relates to experiences of discrimination in the health care setting and health care accessibility (Kugelmass, 2016).

Results from studies included in a meta-analysis by Bailey et al. (2019), which supported that a barrier to initiating and continuing therapy among African Americans was the perception that psychotherapy was associated with weakness and reduced pride, which was exacerbated by the idea that mental illness should be resolved within families or religious organizations, to support the notion of a strong community. In addition, Bailey et al. (2019) reported that among those who do seek help within African American communities, researchers raised concern over self-concealment, or withholding sensitive information to reduce shame, effectively serving as another barrier to positive treatment outcomes related to the depression.

According to Mowbray et al. (2018), African American and Hispanic patients are most likely to discontinue treatment for mental health disorders, compared to other races and ethnicities, and this is true regardless of age. Reasons given for discontinuing treatment included wanting to handle the problem themselves (most common for all races/ethnicities), and for non-Caucasians, a sense of mistrust of providers by the patient, provider-patient racial incongruity, past mistreatment experienced by patients, and the noted cultural and social perceptions and/or stigmas around mental health treatment (Mowbray et al., 2018).

Major depressive disorder is known to present differently across racial and ethnic groups and disparities are evident within different levels of disease in terms of risk factors, presentation, severity of symptoms, and care (Bailey et al., 2019). Bailey et al. (2019) cautioned that given the disparities in seeking mental health care among African Americans, providers should consider social factors in the diagnosis and treatment of mental illness (including depression) among ethnic minorities like African Americans in order to improve mental health care and close the treatment and disparity gap.

Discrimination and Disparities in Mental Health and Clinician Best Practices

Discrimination in the healthcare setting may be a key contributing factor to disparities in health outcomes among African Americans (Mayus et al., 2017). According to prior research, there may be a need to explore the impact of race and ethnicity and historical discrimination as it pertains to health seeking behaviors and health outcomes

(Belgrave & Abrams, 2016; Howard & Navarro, 2016), and how these factors impact healthcare providers who provide mental health care. Further, research supports that clinicians should consider the need to acknowledge and adjust to the unique healthcare experiences and needs of diverse ethnic communities (Taha et al., 2015).

Mental health access and effectiveness of treatment among minority groups, including African Americans, remains lacking and disparate (Curtis-Boles, 2017; Helm, 2018), with the odds of screening positive for depression higher for certain racial and ethnic groups, including African Americans (Hooker et al., 2019), and lower treatment retention (Conner et al., 2010; Davis et al., 2015; Huffman, 2020; SAMHSA, 2020; Taha et al., 2015. This often stems from the insufficient cultural knowledge, bias, lack of consideration, and general inadequacy of care provided (Curtis-Boles, 2017; Lenz et al., 2018). According to Curtis-Boles (2017), clinical best practices include replacing a standard approach with a contextual acknowledgement of racial variances to allow for the patient narrative and lived experience to determine the timing and the way in which subjects are discussed. Clinicians cannot assume racial concerns in the therapeutic relationship will be addressed by the client, and therefore, need to initiate discussion of these potential concerns in the treatment process, and to increase knowledge of African American cultural diversity and the resulting influence on worldviews, clinical symptoms, and proposed treatment (Curtis-Boles, 2017). The clinician-patient bond is critical to a successful person-centered therapeutic relationship (Percival et al., 2017); therefore, characteristics of a successful clinician include the ability to show acceptance and interest, to understand mannerisms and other nonverbal communication, to be interactive, to be an active listener, to share relevant personal information, to be collaborative, and to support patient self-care and empathy (Percival et al., 2017; Hauff et al., 2017).

Yoon et al. (2019) examined perceived discrimination (both racial and non-racial) and the impact on the mental health of older African Americans, identifying the mediating effect of psychological well-being, specifically in terms of having a purpose in life and self-acceptance. The authors examined a subsample of 397 older African Americans from the National Health Measurement Study and found depressive symptoms to be significantly explained by everyday discrimination among both male and female older African Americans but mediated by self-acceptance among males and both self-acceptance and purpose in life among females. Given the positive effect of psychological well-being in terms of self-acceptance and purpose in life, Yoon et al. (2019) concluded the research supports practitioner emphasis on these factors when providing services to older African American clients, as well as addressing racial discrimination in healthcare.

Advances in culturally responsive practice in social work address the impact of social determinants of health, but often fail to acknowledge the impact of systemic racism (Ortega-Williams et al., 2021). The authors asserted that social work, in practice, needs to consider this impact in terms of the unique socioemotional, political, and economic needs of African Americans due to systemic racism and historical trauma. Through this lens, social work seeks to strengthen the micro, meso, and macro level of practice with African American patients to support patient outcomes.

Community-based and Faith-based Practice

Historical and current experiences of discrimination among African Americans contribute to a distrust of healthcare systems, resulting in a reluctance to seeking mental health care and an increased use of family and informal religious sources to treat mental health issues or concerns (Huffman, 2020; Taha et al., 2015). According to research conducted by Chatters et al. (2018), among African Americans, frequent contact with church and family members was inversely associated with depressive symptoms, and that the association of church member interactions and decreased depressive symptomology is independent of family relationship factors and religious service attendance, highlighting the protective importance of church relationships to depressive symptoms among African Americans.

Given the important role of religious sources in supporting mental health in the African American community (Huffman, 2020) and the relative neglect of the clerical role in supporting mental health in the community, Stanbury (2011) explored African American clergy's knowledge and experience in providing pastoral care to African American elders with late-life depression. Using a qualitative methodology, Stanbury studied the ability of the clergy to recognize late-life depression, and their ability to provide mental health support within a mental health literacy framework. Results of the study showed the clergy were knowledgeable, literate, and aware of the need to support elders with depression. In another qualitative study using interviews with 18 African American Baptist clergy to explore pastoral care of older African American congregants with mental disorders, Stansbury et al. (2018) described a central emergent theme of "shepherding the flock," which supported the integral role of the church and the clergy in providing mental health within the African American community and was used to develop a model of pastoral care.

The role of the church for African Americans is significant in the community and as a stress-coping and mental health resource, especially for older African Americans (Nguyen, 2018). At least in part, due to the lack of access and the impact of discrimination and marginalization, African Americans rely on church relationships for assistance and support. Nguyen (2018) concluded that the church can serve as a buffer against the negative effects of discrimination related to mental health among older African Americans. Accordingly, Nguyen (2018) determined that interventions incorporating support given by church members capitalize on a major strength among older African Americans. (Nguyen, 2018)

The role of religiosity/spirituality may be significant in offsetting other factors that reduce the likelihood of older adults seeking mental healthcare services. Older adults are less likely to use mental health services, particularly African American or Caribbean American older adults, which can lead to a decreased quality of life, impacting families, employment, and healthcare systems (Turner et al., 2019). Age is a significant factor in mental health seeking behavior, as is age, sex, and living in the South (Turner et al., 2019). However, a related factor is the strength of religious/spiritual beliefs, which was shown to potentially promote mental health care use among African American and Caribbean Black American older adults despite the effects of age, sex, and geography, and should be examined further (Turner et al., 2019).

Modeling correlates of religious coping and associations of religious coping with treatment acceptability and depression outcomes among an older adult population, Choi et al. (2019) found that both female gender and African American race predicted higher religious coping. Several variables also were significantly associated with a higher religious coping, including active coping, emotional support coping, and clergy consultation on depression. However, religious coping was not significantly associated with the scores on the treatment evaluation inventory or the depression rating scale (Choi et al., 2019). The sample included 277 low-income homebound older adults, somewhat demographically diverse with 70% female, 41% non-Hispanic White, 30% African American, and 29% Hispanic. Choi et al. (2019) also found that once participating in depression treatment, the older adults studied found it “highly acceptable” and found benefit in treatment, regardless of their religious coping. The authors concluded that psychotherapeutic treatment is not only an effective, but an accepted addition to treatment among those demonstrating religious-oriented coping.

Culturally Responsive Mindfulness-based Therapy

Given the multiple variables that create diversity, including cultural characteristics, assimilation, socioeconomics, and religiosity (Curtis-Boles, 2017; Ebede-Ndi, 2016), clinicians must show prudence in postulating conclusions and, rather, should focus on cultivating and using a lens from which to see the client based upon the client’s lived experience in order to more efficiently meet the needs of the client (Curtis-Boles, 2017). This is important when clients, for example, as related to the present study, older Black men and women, underutilize mental health services or fail to sustain treatment relationships possibly due to factors such as stigma, cultural disconnect, and mismanagement of race and racism during therapeutic intervention (Curtis-Boles, 2019). Stigma may be stemming from a combination of within the client's own community as well as the dominant culture (Curtis-Boles, 2019).

The clinician must, therefore, master case management, advocacy, and intervention, while acting is such a way as to empower the client (Curtis-Boles, 2017). The use of thoughtful self-disclosure, the use of a cultural framework, and the ability to relate on a personal and professional level with clients (Curtis-Boles, 2017), can empower clients by bridging the power imbalance between the client and the clinician. Such self-examination is critical to comprehending one's own personal biases and assumptions, supporting more accurate and impartial interpretation of the data related to treatment and supporting minimization of potentially damaging cultural countertransference responses (Curtis-Boles, 2017).

Although mindfulness-based interventions have been shown to be effective in improving outcomes and reducing stress-related disparities, racial and ethnic minoritized populations remain underrepresented in the use of these interventions (Watson-Singleton et al., 2019). Mindfulness-based interventions are flexible enough to be culturally tailored to address unique needs in a given population, such as African American women, and the addition of culturally-relevant mindfulness-based interventions may support reduced health disparities (Watson-Singleton et al., 2019). Watson-Singleton et al. (2019) proposed a mindfulness-based, culturally-responsive intervention model developed through focus group and interview participation following a 4-week mindfulness intervention with a sample population of African American women within Briggs et al.'s (2011) mental health utilization framework. In Watson-Singleton et al.'s research, the authors identified and recommended culturally-responsive modifications to mindfulness-based interventions, such as the use of culturally similar facilitators, the incorporation of cultural values, and the use of familiar terms and resources to a particular culture. Other modifications included setting the intervention in culturally familiar settings, and addressing religious issues, perceived benefit, and holistic health goals (Watson-Singleton, 2019).

Kawaii-Bogue et al. (2017) noted that despite documented health disparities among African Americans and the identified patterns and barriers to effective mental health care and related outcomes, the literature lacks a framework that integrates mental health service delivery for African Americans. Kawaii-Bogue et al. (2017) identified several barriers to access to treatment among African Americans, which include negative stigma, high cost of care, lack of transportation, and lack of or inadequate childcare. In addition, the authors identified barriers to effective treatment as misdiagnosis, disempowerment (in the treatment process), and lack of social support and specialty care. Additional research is needed regarding the barriers and limitations experienced by minoritized population related to mental health services.

To address disparities in retention among African Americans in therapy and improve treatment outcomes, interventions and treatments need to be culturally sensitive, incorporating values, norms, attitudes, beliefs, and practices associated with a client or patient's racial or ethnic group (Jones et al., 2018). Jones et al. (2018) explored (a) whether psychotherapy is an effective treatment among African Americans seeking mental health care, whether there are ethnic and racial differences in treatment outcomes in psychotherapy; (b) what approaches are being used to support cultural sensitivity in treatment among African Americans and is there any evidence that the African Americans are benefitting from such cultural tailoring of treatment; and (c) what improvements to treatments, including culturally tailored approaches, for African Americans are promising?

Treatment outcomes for mental health disorders, such as depression, among African Americans participating in psychotherapy are relatively positive (Jones et al., 2018; Carter et al., 2012). The literature review by Carter et al. in 2012 reviewed 14 studies of psychotherapy use among African American Adults, generally supporting the effectiveness of psychosocial treatments for this population. Further, Jones et al. (2018) summarized reviews looking at treatment efficacy by race/ethnicity to determine whether there is ethnic disparity for African Americans compared to European Americans. Jones et al. reported mixed treatment outcomes, with most studies finding no significant differences in outcomes. Although one study was reported to find weaker treatment effects among African American adults in Cognitive Behavioral Therapy when compared to European Americans, two others (Carter et al., 2012; Huey et al., 2014) found evidence of equal benefits for both groups. With no consistent evidence of disparity of treatment outcomes, the conclusion was that psychotherapy is an effective treatment modality for common mental health problems, such as depression and anxiety, with fairly robust results across ethnic groups (Jones et al., 2018). Jones et al. described limitations to sample sizes of African Americans in the studies and noted that many studies compared outcomes among European Americans to outcomes among "ethnic minority" participants (combined into a single comparison group). Despite the conclusion that African Americans show benefits to psychotherapy in similar ways to European Americans, given that African Americans are less likely to be treated, as well as evidence of disparities in treatment continuation (retention), continued research is needed to understand how psychotherapy may be improved for African American patients and whether cultural sensitivity (or competence) may reduce disparities (Jones et al., 2018).

Generally, research supports that culturally sensitive, or culturally competent, approaches are more effective than no treatment among African Americans with mental health concerns (particularly depression, anxiety, trauma, and substance abuse problems); in addition meta-analytic research has supported increased efficacy of culturally sensitive or tailored approaches to addressing mental health among other minoritized populations, such as Asian Americans and Latino Americans (Benish et al., 2011; Hall et al., 2016; Jones et al., 2018). Examples of culturally tailored approaches are the use of Afrocentric models and client-therapist ethnic matching. Using Afrocentric models, the therapist embeds Afrocentric values, didactics, racial identity, and cultural experiences and history into the therapeutic approach, as well as possibly incorporating faith-based strategies (Jones et al., 2018).

To highlight an example of culturally competent approaches, the *Claiming Your Connections* (CYC) intervention is a therapeutic option for Black women experiencing depression that is focused on development of healthy relationships, social support, and positive self-identity. Jones et al. (2018) explained:

> The program is unique in its inclusion of literary works by Black women (e.g., bell hooks) as a tool to address issues specific to these women's psychosocial environment. The literary works are believed to augment group processes by allowing Black women to identify and discuss important themes relevant to their own lives, identify positive role models, and promote a positive Black female concept. (p. 562)

Although CYC was found to be an effective treatment for depression compared to a nontreatment control group (Jones & Warner, 2011), the treatment was not compared to a standard type of treatment (i.e., one that was not culturally sensitive, but otherwise similar), limiting the ability to decipher whether the cultural aspects of the treatment were associated with the positive outcomes.

Another approach of culturally competent therapy described by Jones et al. (2018) is ethnic matching between the client and therapist, a strategy thought to be effective with African Americans due to shared experiences of racism, even discrimination in health care settings, supporting a cultural mistrust of providers (Jones et al., 2018). This ethnic matching is thought to increase and improve rapport, retention, and outcomes among African American clients.

Research findings suggest that for some African American clients with depression, ethnic matching improved clinical rapport, supporting more openness and vulnerability in the discussion, which may have been stifled due to mistrust or discrimination (Abdou & Fingerhut, 2014; Cabral & Smith, 2011; Jones et al., 2018). It was noted, however, that these studies tended to be correlational, lacking the ability to account for confounding factors (Jones et al., 2018). In addition, research was lacking related to culturally responsive mindfulness therapy among older adult minoritized populations. Continued research is needed to examine the impact of culturally competent treatment options toward reducing disparities and improving therapeutic retention and outcomes among African Americans with depressive disorders, and in particular, older adult African American populations with depressive disorders.

Gap in the Literature

The previous sections described research related to the treatment of depressive disorders among older adults and among minoritized populations, such as the African American population. In addition, the research continues to support the prevalence and consistent increase of depressive disorders in the older adult African American community, as well as the barriers to seeking and participating in mental health care resulting in a low rate of treatment, supporting a need for mental health practitioners in general to be more culturally aware in perspective and practice (Vinson et al., 2014). However, I was unable to find any information in the current research on the perceptions and experiences of mental health professionals providing mental health care to this population of older African Americans.

Qualitative Research Literature

Qualitative research follows a constructivist method, believing that reality is seen through the viewpoint of the participants who have lived experience with a given phenomenon (Tomaszewski et al., 2020). The qualitative research process is designed to engage with the participants, who serve as experts in their own lived experience in order to gain understanding of the phenomenon through the eyes of the participants (Tomaszewski et al., 2020). The process is an inductive rather than deductive process such that patterns emerge during the research process (Tomaszewski et al., 2020). As such, researchers exploring within a qualitative methodology accept the constructivist paradigm that social reality is constructed by those participating (Tomaszewski et al., 2020).

The literature review provides evidence of the use of previous qualitative studies that successfully explored African American barriers to mental health services, retention in formal services, and alternatives to formal mental health services with a focus on interviewing the African American participants to identify and understand their lived experiences. Semi-structured interviews with African American participants were used in studies by Huffman (2020) and Conner et al. (2014) to identify barriers to the use of mental health services among African Americans and to better understand the role of religion as a barrier to the use of more formal mental health services. Huffman (2020), for example, incorporated an interview analysis using interpretative phenomenological analysis (IPA), where the interviews were examined to find interpretative comments and themes from which to draw conclusions. This study built on this prior research to examine the use of mental health services among older African Americans and, more specifically, how practitioners can support providing more appropriate and effective treatment to older African Americans with depression and depressive disorders.

Summary

Research points to the prevalence and continued increase of depressive disorders in the older adult African American community, as well as the barriers to seeking and participating in mental health care resulting in a low rate of treatment from the perspective of the African American community, while also pointing to the need for mental health practitioners in general to be more culturally aware in perspective and practice (Vinson et al., 2014). I was unable to find any information in the current research on the perceptions and experiences of social workers providing mental health care to this population of older African Americans. Research also supports the effectiveness of faith-based and community-based practice, as well as culturally responsive mindfulness approaches. The purpose of this qualitative study is to explore the experiences and practices of social workers who are providing mental health care treatment to African American older adult patients experiencing a depressive disorder. To accomplish this goal, the study used a generic qualitative design (Elliott & Timulak, 2021; Mihas & Odum Institute, 2019) to understand social work practitioners' experiences and approaches to care for the older adult African American population with depression and depressive disorders. The next section details the methodology to accomplish the goals of the study.

Section 2: Research Design and Data Collection

Introduction

The purpose of this qualitative study was to explore the experiences and practices of social workers who are providing mental health care treatment to African American older adult patients (aged 65 and over) living with a depressive disorder. The review of the literature identified a gap in the research in terms of understanding the perspective of the social workers who are providing mental health treatment to older adult African Americans, their thoughts related to the poor treatment outcomes, and what changes can be made to best practices that will support more effectively treating the population of older African Americans. Therefore, I addressed the following qualitative research questions:

RQ1: What are the experiences, challenges, and perceived best practices related to social work practitioners who are providing care to African American older adult patients diagnosed with depressive disorders?

RQ2: How do social work practitioners who are providing care to African American older adult patients diagnosed with depressive disorders describe their practices to improve health outcomes among this population?

The goal of the second question was to provide a deeper narrative description related to the experiences, challenges, and perceive best practices revealed in the first question, which will help to better understand the participants' perceived best practices, based on their own practice, what they are raising up as a best practice or not due to successes and challenges experienced, how they dealt with successes and challenges, and how those successes and challenges were felt to affect their clients, as well as themselves.

Research Method and Design

To address the gap in the research and the stated research questions, I used a generic qualitative design as the methodology. Interviews were used to collect data within a generic qualitative method to explore the experiences of social work practitioners providing care to African American older adult patients experiencing depressive disorders, and also to understand their perspective on research evidence suggesting and supporting that (a) only the small fraction of this population is seeking treatment, (b) there is a low treatment retention among the African American population, and (c) that there are poor treatment outcomes among the African American population compared to the White population.

The generic qualitative research design differs from more traditional qualitative designs, such as phenomenological research, particularly in its focus and analysis (Percy et al., 2015). Generic qualitative research remains focused on drawing out participants' ideas about a phenomenon with a focus on things that are beyond themselves, rather than on the participants' inner feelings (Bellamy et al., 2016). As such, the research method allows the researcher to understand the phenomenon through the perspectives of the participants with the use of a sampling plan that supports a broad range of opinions, including the use of interviews and open-ended survey response data along with a thematic analysis (Bellamy et al., 2016; Percy et al., 2015).

Sources of Data and Data Collection

Data for the study included seven interviews with a purposeful, convenience sample of social work practitioners in Georgia. For recruitment and inclusion in the study, the participant must have a degree in social worker, must be working with African American older adult patients diagnosed with depression or depressive disorder, and must have a minimum of 3 years of experience in the field. Participants were recruited from a Georgia area geriatric mental health professionals group on Facebook, and via email solicitation sent to social work practitioners in Georgia via a publicly accessible Clinical Supervisor Registry (see NASW GA, 2023). The geographic area was limited to the State of Georgia for the purposes of consistency and proximity to me to reduce associated costs for the research. Participants were recruited via email or messaging to the entire group of participants through the geriatric mental health professionals Facebook group and via email solicitation sent to all social work practitioners in Georgia as described. Potential participants who respond that they were interested in the study received, via email, further information about the study through the informed consent form, which detailed all aspects of the study, as well as the contact information for the researcher. As the researcher, I set up a time to call the potential participants to discuss the study and, if the participant met the inclusion criteria and was willing to participate, a date and time was set up for a Zoom interview.

The sample size of seven participants was based on the anticipated availability of participants and the recommendations for specific sample sizes in qualitative research related to achieving data saturation. Qualitative research typically incorporates smaller sample sizes, in contrast to the relatively large sample sizes recommended to support validity in quantitative research (Cobern & Adams, 2020; Creswell, 2017a, 2017b). According to Creswell (2017a, 2017b) and Polkinghorne (2005), recommended sample sizes for a qualitative sample generally fall between one and 25 participants.

Cobern and Adams (2020) discussed appropriate sample size when including interviews as a means of data collection. This discussion was centered on saturation of the data, described as when one no longer discover new responses in the data (i.e., similar responses repeat over and over across different participants), indicating the researcher has reached saturation. According to Cobern and Adams, a convention of between 15 and 20 interview participants is generally accepted as a point at which one would expect to reach saturation. Therefore, the proposed sample size for the present study was 7-10 participants and the actual sample size obtained for participation in the study was seven.

Instrument

As the researcher, I developed semistructured interview questions designed to address the identified gap in the research in terms of understanding the perspective of the social workers who are providing mental health treatment to this group, their thoughts related to the low retention and poor treatment outcomes, and what changes can be made to practice that would support more effectively treating the population of older African Americans. Participants were invited to share their experiences, perceptions, and meaning derived from and relating to providing mental health care to older adult African American populations diagnosed with depressive disorder and participating in a therapeutic relationship, and perceptions of challenges and best practices related to providing mental health care to this population. Interviews were audio recorded and transcribed into a Word document for use in thematic analysis. The interview guide with the questions that were asked during the interview with each participant are included in Appendix B.

Data Analysis

I used a thematic analysis to analyze and interpret the interview data obtained for this research. This approach was chosen because it can provide the researcher with tools and strategy for conducting, organizing, and interpreting the qualitative data analysis toward creating a narrative understanding that will highlight commonalities and differences in the participant responses (see Crowe et al., n.d.). Nowell et al. (2017) outlined a six-step process for conducting thematic analysis that meets the trustworthiness criteria outlined by Lincoln and Guba in 1985. Nowell et al. noted that although the process as outlined is linear, it is an iterative and reflective process, developing over time and fluctuating between phases. The following phases of thematic analysis, as outlined by Nowell et al. were followed for the analysis of the data.

Step 1 involved becoming familiar with the data. This step includes prolonged engagement with the data (reading and re-reading); documentation of researcher notes, reflections, and potential codes or themes; and the use of field notes, transcripts, and reflexive journaling (Nowell et al., 2017).

The second step involves the development of codes from the data, which is described as a “theorizing” activity requiring the research to visit and revisit the data (Nowell et al., 2017). The coding process is reflective, as the researcher interacts with and thinks about the data. Through the coding process, the researcher simplifies and focuses the data. This is accomplished by identifying important text and labeling and indexing the text as it relates to a theme (Nowell et al., 2017).

Step 3 involves searching for themes in the data. After all the data have been initially coded and collated, with different codes identified across the data set, the researcher attempts to sort potentially relevant coded data extracts into themes (Nowell et al., 2017). Themes represent key concepts that link substantial portions of the data together (Nowell et al., 2017).

As the researcher, after I identified a set of themes, I completed Step 4 by by reviewing the coded data extracts in each theme to see if the form a pattern (see Nowell et al., 2017). Step 4 helped me determine whether the themes accurately reflect the meanings in the data, supporting validity of the data (see Nowell et al., 2017). Inadequacies or issues with the initial coding and themes may be identified requiring changes, such as adding or deleting codes, or combining themes.

In Step 5 I described the data each theme captures by naming the theme. For each theme, the researcher creates a detailed analysis to identify the narrative for each theme (Nowell et al., 2017). In addition, I considered how each theme fits into the overall narrative for the whole data set in relation to the research questions of the study (see Nowell et al., 2017).

In the final step, I took the established themes and generates a concise, coherent, logical, non-repetitive, and interesting account of the data, both within and across the identified themes (see Nowell et al., 2017). Direct quotes (i.e., raw data) from participants are embedded in the analysis narrative and included as essential components of the report to help the reader understand the complex story of the data, transcending description and supporting validity of the analysis. In this process, I use both brief quotes to support understanding of specified points and extensive quotes to provide the reader insight into the complex story described (see Nowell et al., 2017).

Cobern and Adams (2020) provided a discussion and explanation of the concept of generalization in research, confirming that generalization of qualitative data is inappropriate, and offering and justifying the use of different wording in place of generalization. Cobern and Adams supported the use of the terms that describe the findings as “indicative” and “suggestive” rather than discussing generalizable data.

Ethical Procedures

Ethical procedures are critical to supporting validity of the qualitative research, as ethical protections serve to support participant comfort level and ability to speak freely (Kanyangale, 2019; Morse & Coulehan, 2015; Sanjari et al., 2014; Vivek, 2022). Interviews were conducted using Zoom meeting space due to the COVID-19 pandemic. The Zoom meeting offers the participants a private, comfortable location for the interview, which supports participant sharing and candor. Although in interviews, the participants cannot remain anonymous, as the researcher, I provided each participant with a pseudonym to protect participant confidentiality. No personal identifiable information was collected from participants.

In addition, all participants signed an informed consent form prior to participation in the study. Informed consent forms were emailed to the participants and asked to be returned to the researcher prior to the time of the interview. As the researcher, I was available to answer any questions the participant may have had about the consent form via telephone or during the zoom conference call. The consent form and consent process provided a thorough explanation of the study purpose, study procedures, and any risks and benefits to participation in the study to support the consent process (Kanyangale, 2019; Vivek, 2022). Once the consent form was signed and returned by the participant, the interview process began.

The zoom interviews were recorded using the zoom “record” control function (which records the zoom session) and the interviewee agreed to being recorded via zoom. As the researcher, I transcribed the zoom sessions into a Microsoft Word document for data analysis. The recorded data and the transcribed data in the form of a Word document were stored on a password protected thumb drive and the drive will remain in a locked filing cabinet at the residence of the researcher for 5 years, the required amount of time, and then destroyed. Lastly, as the researcher, I used reflexive journaling (reflexivity) throughout the ethical process related to data collection and analysis to avoid potential bias as much as possible and to support the ethical process in qualitative research, as described by Kanyangale (2019).

Summary

As outlined in the methodology, this study used a generic qualitative research design that incorporated interviews with a sample of seven participants who were invited to share their experiences, perceptions, and meaning derived from and relating to providing mental health care to older adult African American populations, participating in the therapeutic relationship, and perceptions of challenges and best practices related to providing mental health care to this population. Data obtained from the interviews were analyzed using thematic analysis to address the research questions of the study. Section three details the results of the data analysis and the findings of the research, followed by Section 4, which relates the findings to the previous literature and the field of practice.

Section 3: Presentation of the Findings

Introduction

The purpose of this qualitative study was to explore the experiences and practices of social workers who are providing mental health care treatment to African American older adult patients (aged 65 and over) living with a depressive disorder. There are difficulties with retention in mental health treatment (i.e., keeping clients engaged in and compliant with treatment) and poorer outcomes among African Americans (Conner et al., 2010; Davis et al., 2015; Huffman, 2020; Taha et al., 2015). There was a gap in the research in terms of understanding the perspective of the social workers who are providing mental health treatment to this group, what their thoughts are as it relates to the lack of retention and poor treatment outcomes, and what changes can be made to practice that will support more effective treatment of the population of older African Americans. Therefore, this study was designed to address the following qualitative research questions:

RQ1: What are the experiences, challenges, and perceived best practices among social work practitioners who are providing care to African American older adult patients diagnosed with depressive disorders?

RQ2: How do social work practitioners who are providing care to African American older adult patients diagnosed with depressive disorders describe their practices to improve retention and health outcomes among this population?

Data for the study were collected from interviews with a purposeful, convenience sample of seven social work practitioners in Georgia. For inclusion in the study, the participants must have had a degree in social worker, must have been working with African American older adult patients diagnosed with depression or depressive disorder, and must have had a minimum of 3 years of experience in the field.

Section 3 includes a discussion of the data analysis procedures and techniques used to conduct the qualitative analysis of the interview data. The findings and themes revealed from the analysis of the interview data are presented. Finally, a summary of the section is provided along with a description of the following section.

Data Analysis Techniques

Data for this study were collected via interviews conducted over a 3-month period from December 2022 through February 2023. Interviews were audio recorded with permission of participants. As the researcher, I transcribed the audio recordings into Microsoft Word. I emailed the transcribed interview data to the participants, who were asked to review the transcription (member checking) for validity. The transcribed interview data were then uploaded into Atlas.ti qualitative analysis software (ATLAS.ti, Version 22.0.6.0, 2022). Seven interview participants were recruited and participated in the study.

As described in the previous section, the study design included the use of thematic analysis to analyze and interpret the interview data collected from the seven participant interviews and to create a narrative understanding that highlights commonalities and differences in the participant responses (see Crowe et al., n.d.). I used the six-step, iterative and reflective process outlined by Nowell et al. (2017) for conducting thematic analysis, which included (a) becoming familiar with the data; (b) generating initial codes;

(c) searching for themes; (d) reviewing themes; (e) defining and naming themes; and (f) producing the report.

To aid in the facilitation of the analysis process, Atlas.ti qualitative analysis software (ATLAS.ti, Version 22.0.6.0, 2022) was used, providing an organized workspace in which to code and track the qualitative interview statements made by the participants. In this process, I uploaded the interview transcripts into Atlas.ti, and was able to label and index relevant text as it related to the theme or research questions of interest. Coded responses were sorted or categorized into themes representing key concepts that link portions of the data together to generate a narrative of the phenomenon (Nowell et al., 2017). Direct quotes, both brief and extensive, taken from the interview transcripts of participant responses are embedded in the analysis narrative and included as essential components of the report to help the reader understand the complex story of the data and supporting validity of the analysis (see Nowell et al., 2017).

Description of the Sample

For the study, I interviewed a total of seven social work practitioners in one-on-one interviews that lasted approximately an hour. These participants represented a diverse group of interviewees obtained from the population of practicing social workers in the Georgia area. Table 1 provides some demographic descriptions of the sample used in the study. It is noted that participants were asked to self-identify in terms of race and ethnicity and social work practice, as with the other data, supporting slight differences in terminology by participant.

Table 1

Interview Sample Characteristics

Participant	Age	Self-described race/ethnicity	Self-described social work practice	Years in the field
1	45	Caucasian	Psychotherapy; congregate care and private practice	21
2	42	Black/Jamaican	Mental health/ geriatric	5
3	61	African American, not Hispanic or Latino	Clinical therapist	3
4	30	Black	Social work/ therapy, geriatric	10
5	55	African American	Individual, family, and couple counselling, mostly geriatric	30
6	41	Black	Geriatric mental health and wellness	3
7	33	Black Hispanic	Family therapy, clinical assessment	5

Findings

The findings of the analysis of qualitative interview data are presented according to the associated research questions. Participants in the study first described their own experiences and what brought them to working with African American patients with depressive disorders. This descriptive data related to the participants' experiences was used to assist me, as the researcher, in understanding the participants in this study and framing their responses within the context of their work experiences. Participants in this study described working with diverse populations, with a significant proportion (75-80% or greater) of their current caseloads comprised of African American clients with depressive disorders. Participant 1 reported that roughly 90% of the caseload was comprised of African American clients with depression. Participant 1 explained:

> When I get the referral, there's already been a screening done. Because I'm billing for psychotherapy services. So I would not have anyone on my caseload who did not have a diagnosis identified in the DSM … Yes, 90% with depression and anxiety.

Similarly, Participant 2 noted, "About a third of my patients are African Americans and more than 50% of them are diagnosed with depression." Participant 7 also stated:

> The geriatric community I worked with was comprised mainly of African American clients – roughly 60-70%. About 20% being of mixed race, Asian, or Hispanic clients and the remainder working with clients who are classified as white racially. … Based on assessment findings, the 60-70% of the African American geriatric communities met assessment criteria for MDD at a rate of approximately 30-40%.

The participants described high rates of depression and for this older adult population, there is a coexisting confusion due to life changes, and often a lack of family interaction.

> So the depression is high, you know, they don't understand why they're there most of the time, because that dementia kind of makes them forget. So they don't understand why they're there. They don't understand where their family is, they don't understand, you know, what's going on really most of the time. And so you see where that depression is high, and it kind of impacts our work, because sometimes it's kind of hard to pull them out of that. Because, you know, like I said, I'm only there for an hour a week. They're there, you know, all week kind of

> experiencing that. So it's challenging, and I think that you know, they're really going through and I have that support. (Participant 4)

Participants also commonly described working with underprivileged populations, with patients with severe behavioral and mental health issues and neurocognitive problems like dementia, and with patients in nursing homes. Participant 2 detailed how she was drawn to working with this population:

> Regarding my experience thus far, I tend to mainly deal with the underprivileged, live underprivileged population when it comes to the geriatric population. You know, it almost seems as if I am drawn to that class of society where, you know, nursing homes, they're either in nursing homes, where they're getting assistance from the government, these places are usually not the best of the best, because, you know, it's what they can afford, based on what they get from the government, Medicaid, Medicare. So my population, the geriatric population that I've dealt with mostly involved, lower class citizens. Diagnosis, a lot of depression. And a lot of these diagnosis as are as a result of, you know, just significant life changes, they can't be home anymore, they can't take care of themselves. Loved ones, have kind of put them aside, in a sense, brought them to nursing homes, assisted living facilities, and don't visit, anxiety about the future.

Other participants described the diversity of their clients, such as Participants 3 and 4, who described working with different racial and ethnic populations, as well as working with different diagnoses.

> My patient population is mixed. I currently have 23 patients. Caucasian patients are 13. African American patients is 8. Diagnosis: adjustment disorder; mixed anxiety; major depressive disorder; generalized anxiety, isolation, and PTSD. Some have experienced loss of parents, loss of spouse; loss of children, and there is the change of living with children, and caring for sick family members such as husbands. Jewish is 2: lives alone with no family and has never been married. Does not have any children. Gay. Diagnosis is Major depressive disorder. (Participant 3)

> Yeah, so I have a, I have a pretty half and half range. Um, so I started out with eight nursing home patients, um, two of which are Caucasian, and the other six are African American. And they all are diagnosed with dementia, Alzheimer's, and then depression. So, and then you have a few of them that have, I have two that have bipolar. So um, so that's kind of the diagnoses and the race breakdown. (Participant 4)

Another common description of the work was that of advocating for the older adult population.

> I thought about becoming a nurse and I did start the course, but I was not feeling it. The spirit of advocacy was strong on the inside and so I changed my major to social service. I really was inspired by the residents that I was providing care for. My goal is to continue working with geriatric population and continue being their advocate. I also want to be a geriatric consultant, where I provide the best

> resources and services for families and their loved ones as it relates placement. (Participant 3)

In addition to feeling the need to advocate for their patients, participants also commonly described being comfortable working with a diverse older adult population. Participant 1 said, “I do feel comfortable with the population; I guess it's working into a niche.” Often this comfort stemmed from years of prior experiences with geriatric, mental health, or other related experiences. Others described also having some level of anxiety related to barriers to care.

> I have spent 35 years in this field. I started from 18 When I adapt into nursing, following my mother, who is a nurse and a social worker, and then it started really from there from high school up till now, all my positions that I've had, I've dealt with geriatric patients, mental health, dealing with substance abuse, as well as homelessness. So, I guess it started from a young age, both of my parents were into helping others, and I just fell into the geriatric population. So it started from a very young age. (Participant 5)

Table 2 provides a list of thematic responses and the number of coded responses related to each theme describing the participants’ work experiences, highlighting each experience and description.

Table 2

Personal Work Experiences

Response	Number of times response was mentioned among the interview participants
Caseload with Depression	12
Diverse populations	8
Comfortable with older adult population	5
Helping others	4
Advocate for older adult population	1
Working with neurocognitive disorders	2
Positive experience working with AA population	1
Underprivileged population	1
Work in nursing home	1
Have anxiety related to the barriers	1
Working with severe behavioral and mental health	1

Research Question 1

The first research for this study was *What are the experiences, challenges, and perceived best practices among social work practitioners who are providing care to African American geriatric patients diagnosed with depressive disorders*? Three categories of responses were revealed in the interview data that served to address this research question. These include responses related to the thematic categories of (a) the impact of race and the associated barriers to diagnosis and treatment, (b) the lack of empowerment among patients, and (c) recommendations for best practice. From these three categories of responses, several themes were highlighted. These are discussed further according to the two categories.

Impact of Race

Themes revealed under the category of responses related to the impact of race and the associated barriers to diagnosis and treatment included differences in the experiences of African American patients compared to white patients. The responses in the category of impact of race highlighted themes of (a) African American cultural aversion or resistance to therapy (five participants; although with the caveat that the higher the educational level of the client, the more accepting of therapy they seemed to be); (b) differences in diagnosis and treatment based on race (5 participants); (c) African American client mistrust of medical personnel (3 participants); (d) fewer family visitations among African American clients (2 participants); and (e) differences in activities and engagement, treatment and outcomes based on race and socioeconomic status (2 participants).

Cultural Aversion to Therapy. Five participants described the impact of race in terms of a cultural aversion among African American clients to participating in therapy, felt likely due to stigma and other cultural notions of mental illness. Participant 6 described how for White clients, mental healthcare is normalized, whereas for people of color, and particularly the Black community, the need for mental health services is seen as a weakness, making the clients less receptive to therapy.

> [With] clients who are not of color, it’s as if mental health services is normal, it’s normalized for them, they have seen therapists in the past, their children and their grandchildren are seeking therapy at the moment. So, it's very normal for them to sit down with me and just have conversation and fill me in on things that are

> happening in their lives and ways in which they feel. So, it’s not as tough having a conversation with them. However, within the Black community, it is for them, it’s, saying something’s wrong, with they say that I’m dealing with depression, so to speak. … And so I think for the African American community, they’re a little less receptive. So it takes time; it’s takes that patience. That I feel I bring to the conversation the patience and the consistency it takes my willingness to sit with them and listen to them in order for them to open up, and it has taken time. And honestly, I would say, roughly, it has taken maybe 2, 1 or 2 months, honestly, really, [for] some of them to open up and accept the fact that we can do this together. But their willingness has to be there as well. (Participant 6)

This aversion to therapy was noted to be particularly strong among African American men, who saw themselves as providers. Participant 6 described the following:

> [The] male clients that I see are, they are Black. And so for them, it's been a little more challenging, because their frame of mind, from the very beginning has always been I'm the provider. I take care of my family. I don't need anyone coming in and telling me otherwise, or how, how things are now, for me. So that has really been a barrier or challenge for me. But I've met the challenge with every client. Again, that's where my passion comes in, and remaining consistent for them.

Participant 7 noted that African American clients often minimized their mental health challenges. This participant stated, “My experience has been that they often minimize their challenges with depression and attribute their anhedonia and sleep disturbances to moral failure or lifestyle choices."

To address this issue, Participant 2 described the strategy of not calling it "therapy" but rather, just calling it a "visit."

> Well, I'd say firstly, a lot of African Americans are not interested in therapy. Probably if you say I'm just gonna come and sit with you. Okay. But once you mentioned therapy, not this population is basically believes that hey, you're saying I'm crazy. Or you're saying I need emotional help, and I don't need anything from anybody. … Sometimes I don't use the word therapist. And I get a better welcome. Yeah, they're more welcoming. Hi, you know, I'm just here to sit and talk. … There's this older woman there, I forgot her name. But I talked to her every day when I go into see my other clients. And she's friendly, and we laugh, but she's identified me as a therapist. So, she'll laugh and talk with me for a few minutes. But then she moves on. Because she does not need therapy. That's what she's she said, she's told herself, it's just the stigma attached to a therapist and mental illness. And you know, once you say, therapist, this population automatically believes that, hey, something's wrong with me mentally. That's why I need a therapist. And it's just, it's pretty prevalent in the African American Black narrative.

This was also mentioned by Participant 3, who described:

> The challenges that I have encountered include focusing on their diagnosis. After the first two sessions or so, there is usually the tendency to say "I am ok";

> “nothing is going on”; I am alright, and excuses to get off the phone. It can get very awkward because this behavior is a barrier to treatment and thus can prevent the patient from getting the help that they need.

Participants noted multiple factors that may support this aversion and distrust among the African American community. Participant 6 described differences in resources, including location and insurance, among non-Black communities that support acceptance compared to Black or African American communities.

> I just don't feel as though, just based off, of course, statistics, but then also, considering my caseload. I just don't feel as though it's talked about within black community as much as it should be. And I think that plays a part in it, because we are addressing their needs, is a lot of defense, the defense mechanisms, you know, are heightened. Ask a lot of questions, which is perfectly fine. But comparison, there's a drastic difference compared to the non-Black community. I'm thinking about resources even, knowing that or people of color. Insurance plays a factor. Thinking about location, even location for facilities or treatment facilities, education behind it. (Participant 6)

However, with greater understanding, there seems to be a desire to get better.

> It starts from, I guess, their upbringing. Like I said before, a lot of them were raised with the Don't Ask, Don't Tell policy where, you know, it wasn't cool to go back and say you were hearing voices, or for them to say, you know, I'm unable to sleep, I feel sad and I cry all night. Those were things that they didn't talk about. So I see that now, they are becoming more aware of what depression, anxiety, and

> just needing to be mentally intact looks like and they want to get better. And I see it in all my patients, I see the desire to get better. And I actually could see the change. (Participant 5)

Education and Awareness Reduces Cultural Aversion and Improves Acceptance to Therapy. As a commonly noted sub-theme to cultural aversion to therapy, nearly all the participants described that clients who were more educated and/or had greater awareness of mental health issues had a greater level of acceptance of therapy.

> And then, and then there are others, like I do have a few. But it's, you know, it's a lesser percentage who are open. And the truth is that a lot of the ones who are more open to therapy are the ones who are more educated. … You know, when you look at the percentage of it, if you were to calculate it. For me, my experience, it might not be a significant percentage. But I've noticed that the more educated ones are more open to therapy. It could be that, hey, they read more, they listened to the news more. They're aware of the changes happening in today's society where mental health is concerned, where it's not frowned upon, where they're better able to articulate their fears, their needs, and so they're better able to understand what is needed based on you know, having a good understanding of what they're experiencing. You know, I'm sad. I'm crying a lot these days, which could only mean that I'm going through something that I might need help, additional help that this is something I cannot do or take care of on my own. And

> so here comes a therapist. Hello, I'm [therapist name], I'm going to be your therapist. Okay, yes, I have been needing to talk to someone. (Participant 2)

Therefore, there was an expressed need for increased awareness to improve acceptance of therapy on a cultural level. Cultural differences and misconceptions about therapy can be addressed proactively with increased awareness. According to the fifth interview participant:

> We need to put more awareness out, even though it's out there is not out there, let's say because in every state is different. I'm born and raised from New York. So for us, their mental health, what it looks like, wasn't what it looks like here in Georgia, a lot of people are slowly coming to understand what depression looks like. And I think we need to put more awareness out, we need to be able to be everywhere, so people can know it's okay, and we're here to help. This place is to help them. One person that I had actually thought being mentally ill meant you had to be [an] inpatient and put into what they quote unquote, called a crazy house. That's not true. You know, it's a misconception of what mental health is, what it looks like, and what can happen from it. So I think, you know, we need to be more proactive, we need to get the word out that mental health doesn't make you crazy.

Participant 6 agreed noting the need to increase education and awareness toward greater acceptance of therapy and improved therapeutic outcomes among African American populations. This participant stated:

> So a lot of times, it's educating them. It's sitting down with them and explaining to them the benefits of early detection of awareness within them know how it hits differently for black community than it does the other and just really validating them in their feelings. And explaining to them that doesn't necessarily mean that there's something wrong with you. That there's a real reason in why you're not able to sleep, there's a reason why your appetite has changed or you're, you're not getting adequate amount of rest. And that reason was reasons I contributed to this illness. And so it's major depressive disorder are most of the patients in which I see as well as persistent? (Participant 6)

Dismissal, Misdiagnosis, and the Resulting Distrust. Another theme from the participant interviews was that African American male older adult patients were often dismissed when complaining or bringing up issues and/or were misdiagnosed, which further contributed to a distrust of the medical system. Although distrust of the medical community among African American populations is not a new concept, the findings here support the notion that dismissal of symptoms and misdiagnosis may be exacerbating this suggested cultural norm. Two participants (2 and 7) described how African American older adult patients were often dismissed, with staff failing to dig deeper to uncover the real issue or problem, which often resulted in misdiagnosis.

> Where nurses concerned, let me ensure that I give you your medication, for diabetes, you don't feel like taking your medication today, oh, you're just being difficult, it has nothing to do with the fact that you are hurting emotionally. So I see that a lot of when I do speak to the other members of the company or nurses,

> the other employees, staff members, I realized that they don't think as deep as or look as deeply as the way a social worker would or therapist would. … They're dismissed. They're overlooked. I'm here to give you your diabetic medication. I'm here to give you your medication for whatever anything that's outside of any kind of emotional psychological distress. (Participant 2)

These types of actions or failure to act likely compound problems related to the generally accepted notion related to cultural distrust of the medical community among African American patients, which was noted to be getting worse, not better, by the first interview participant, who said, “Sometimes a person, there's distrust with the medical community. I don't think that's getting better. Might be getting worse here lately. like could distrust with authority in general.”

Participant 7 noted disparities in the treatment of African American clients resulting in distrust in the medical system.

> I believe race does impact the diagnosis and treatment of depression in AA communities due to the disparities in AA people being able to secure assistance that is culturally competent. I have had clients in the past make statements like, ‘the system just wants our money’ and feeling like their psychological challenges with depression were “made up.” (Participant 7)

One participant also noted African American clients to be diagnosed more often with conduct issues than with depression. Although this was mentioned by only one participant, it was a significant finding and so was highlighted as a theme from the data.

Participant 1 said, “I can see how they can be diagnosed with more conduct type stuff, rather than it being identified as depression.” This finding needs further investigation.

Lack of Family Visitation. The study participants noted a lack of family visitation among African American clients who live in nursing facilities, which may be the results of multiple factors, such as access to transportation, or even the commonly cited stigma toward mental health issues within the African American communities. Participant 6 described this lack of connection to family and lack of visitation, which was described by this participant as often the result of difficulties with transportation.

> I will say a huge, a huge factor is just connecting with their families, often understanding that I'm sometimes the only person that the African American patients in which I see, that I am the only person that sometimes they do see for months at a time outside of their med techs and the nurses that come in and visit them on daily but connecting with their families is oftentimes a challenge. getting a hold of someone, making them aware of you know, something that might have been a little, alert a little bit, just connecting with their families. A lot of times, it's just one of those, come see, I’ll come see them when I can. And that's understandable as well. That has been a hardship for many of them. So getting accessibility, a lot of these facilities are not necessarily on traveling line, I am because the transportation is an issue. So a lot of the patients or children don't drive, a lot of the patients, they have to rely on the resources to get to visit them. And so the transportation is an issue, there's no bus line. They can't necessarily

> get to them the way they wish. So I definitely see accessibility as a huge issue relates to this. (Participant 6)

Differences in Activities, Engagement, and Outcome based on Race and Socioeconomic Status. Participants described differences in activities and engagement as well as treatment outcomes based on race and/or socioeconomic status. One participant described differences in patient activities based on race, with African American patients being offered fewer engaging and interactive activities.

> In diagnosis, in my experience, I would say no, because just as well as my African American clients have it, my Caucasian clients also have the depression diagnoses. What I do see, however, is the support differential. So, for example, when I was going to some of the nursing facilities that have more Caucasian residents, all kinds of activities, all kinds of people coming in and out, there's that support that’s there, and there’s that camaraderie around trying to get them out of that depressive state and get them engaged. Whereas with my African American facilities, or where there's primarily African American residents, you don't see that you don't see any activity. You don't see it, most of them. Unfortunately, there are some good ones like Medlock is a good one. But then there are some that you just don't you don't see the activity, no one's kind of pulling them out of the room. Hey, listen, we're doing this kind of like, let's engage. But at my Caucasian, primarily Caucasian facilities, you see that a lot. They're pulling them out of the room, hey, we're doing this Come, come join. Hey, sorry, here's a menu

> of what we're doing this week, not just the big one that's in the front. Let me bring one to your room. And so it's a difference there for sure. (Participant 4)

Another aspect to this theme revealed in the interviews was race as a factor in treatment and outcomes among African American and other patients with depression depends on the socioeconomic surroundings.

> If we were talking about a nursing home assisted living that had a diverse population or in terms to socio economic status, yes, I think more so than anything. It does. It does play a part in that, however, my experience with working with the underprivileged geriatric population in nursing homes and assisted living depending on the quality of the assisted living facility, it's usually ignored. For the most part. (Participant 2)

Participant 7 described understanding the challenges of marginalized groups from personal experience, which made her feel more able to help her clients.

> The challenges I have met are related to working as a liaison for services with their other medical providers who were often White or Asian. Being a Afro-Latina social worker often aided in clients feeling seen and understood due to sharing many experiences being part of a marginalized group.

As therapists, given social differences, the participants described the importance of understanding the patient's background and experiences to help understand what the patient brings into the therapeutic relationship. Participants 1 and 5 described this in their own experiences:

> You know, and so I just try to explore the background and get a sense of, you know, when the person could be carrying into the relationship or may not, but I try not to treat it with absolutes. (Participant 1)
>
> Yes, I think it does. And it starts from, I guess, their upbringing. Like I said before, a lot of them were raised with the Don't Ask, Don't Tell policy where, you know, it wasn't cool to go back and say you were hearing voices, or for them to say, you know, I'm unable to sleep, I feel sad and I cry all night. Those were things that they didn't talk about. So I see that now, they are becoming more aware of what depression, anxiety, and just needing to be mentally intact looks like and they want to get better. And I see it in all my patients, I see the desire to get better. And I actually could see the change. (Participant 5)

Table 3 provides some key themes in the responses related to the impact of race and barriers to diagnosis and treatment with verbatim examples from interview participants.

Table 3

Impact of Race and Barriers to Diagnosis and Treatment

Response	Number of times response was mentioned among the interview participants
More educated, more open to therapy	8
Challenge of engagement to pull into therapy and then back to normal	3
Patients dismissed and staff do not dig deeper	3
Lack of family visits among AA	2
Race as a factor depending on SES of surroundings	2
Difference in activities and treeatments offered by race	2
Distrust of Medical community or authority	2
Difficult dynamic with AA CNA and Caucasian male	1
AA men may be diagnosed with more conduct issues than depression	1
Understanding background and what carrying into relationship	1

Lack of Empowerment

A key theme revealed from common participant responses was the sense of a lack of empowerment for the African American patients with depressive disorders. This lack of empowerment showed in themes ranging from feelings of abandonment to experiencing a lack of autonomy and the use of medication refusal as a means of regaining autonomy. These themes are discussed individually with verbatim examples from the interview text.

Feelings of Abandonment. The participants described patients feeling abandoned, particularly in light of the lack of visitation from family and friends noted in the previous section. "*Well, lot of the cases that I've come across has to do with mostly African American Geriatric individuals being abandoned"* (Participant 2). This was echoed by the fourth interview participant, who described:

> It's interesting, because what I found is, unfortunately, specifically my African American clients, out of the five of them, only two have family members that visit them. And so what I've noticed is that they really embrace me when I come in; they are really looking forward to me visiting once a week and being able to spend that hour with them.

Loss of Autonomy. With life changes, like growing older, and particularly among older adult patients in nursing homes, participants were described as experiencing a loss of autonomy. The second interview participant described how clients begin to feel a loss of autonomy with increasing age that results in feelings of sadness and contributes to depressive symptoms.

> Essentially. And with that, you have the fact that they've gotten to an age where they're no longer able to do for themselves, they've, they've lost autonomy, and with that, in and of itself, you know, triggers that triggers a sense of less than a sense of failure a sense, just sadness comes with, with not being able to operate at a level that you know, your once you were once accustomed to. (Participant 2)

Participant 2 continued to describe how the life changes associated with aging and being moved to a nursing home or similar living condition.

> And, and then so there's that just typical life changes, and then you have, oh mom, I can't take care of you, or dad, I can't take care of you, I'm going to have to put

> you somewhere. And putting you somewhere usually results in maybe one once once a visit, once or twice a month to know visit phone calls that eventually stopped coming too and, you know, so that really just it really cements it for some of these individuals regarding okay, this is my life now. I am no longer this person, this is who I am. How do I deal with this life change that has to do with your physical space to do with, you know, not feeling needed anymore?

Finally, the interview participant 2 described how these changes are often compounded by lack of visitation and isolation.

> And, and then so there's that just typical life changes, and then you have, oh mom, I can't take care of you, or dad, I can't take care of you, I'm going to have to put you somewhere. And putting you somewhere usually results in maybe one once once a visit, once or twice a month to know visit phone calls that eventually stopped coming too and, you know, so that really just it really cements it for some of these individuals regarding okay, this is my life now. I am no longer this person, this is who I am. How do I deal with this life change that has to do with your physical space to do with, you know, not feeling needed anymore? …truly accepting and identifying that there's depression, understanding the triggers, understanding and accepting the life changes that have come as a result of aging. Um, a lot of a lot of my patients love to reminisce. And so there is a lot of beauty and comfort in memories. You know, and also identifying that, you know, kind of holding on to the past, in a sense, while also finding a way to deal with the present.

Medication Refusal to Empower. According to the participants in this study, as a reaction to the feelings of loss of personal empowerment, clients often “act up” by refusing to participate in their care regimen. Participants described how often patients use medication refusal as a means of gaining a sense of empowerment because they may feel like that is the only control they have. Often, patients do not even know what they are taking and why. “Most of the time, there, some people are not even really aware of what they're taking and what it's for their own situation situations where the patient would ask the nurse and the nurse, the patient will say that the nurse won't tell them” (Participant 1). Participant 1 continued to explain:

> Sometimes a person may not want to take their medicine. Or sometimes the patients in general will use refusal of their meds and for power in a situation where they feel like they're not empowered or not in control, like they may want something, and they'll withhold it, they can't get it. And sometimes that's reasonable, and sometimes it's not. And then they won't, they will not take the medicine.

This lack of empowerment was felt to be so extreme that participants described it as being worse than being incarcerated. “The phrase that is stated to me a lot is this feels like being incarcerated, or this is worse than incarceration. Yeah, and just because they haven't been able to, you know, sometimes even their mobility in the facility” (Participant 1). Table 4 provides the participant responses toward describing the lack of empowerment and verbatim examples.

Table 4

Participant Responses Related to a Sense of Lack of Empowerment

Response	Number of times response was mentioned among the interview participants
Feel abandoned	4
Life changes	2
Loss of autonomy	1
Patients don't know what they're taking	1
Patients use medication refusal as empowerment	1
They feel it’s worse than incarceration	1

Recommendations for Best Practice

Participants offered recommendations for best practice when working with African American older adult patients with depressive disorders. The full list of recommendations offered is included in Table 4. The most commonly noted recommendations highlight key themes and include (a) increasing awareness to reduce bias; (b) providing caregiver training that will help caregivers advocate for patients, reduce stigma, and identify reportable changes in behavior to support identifying successful treatment options; (c) the need for ongoing training opportunities for providers to support self-awareness and bias training and further reducing stigma, remove labelling and bias, and better demonstrate respect for the person; (d) in building therapeutic relationships, matching patients and therapists more effectively or using partnering techniques to provide better therapeutic matches; and (e) provide more opportunities for engagement.

Increasing Awareness, Reducing Stigma, and Advocating. The first recommendation was to focus on ways to reduce the stigma around mental health issues.

A reduction of stigma could potentially have many positive outcomes, including to help increase participation, particularly among the Black and African American populations, improve family visitation and participation, and improve the client-therapist therapeutic relationship. Reducing stigma requires an increased awareness and understanding of mental health. Participant 5 explained:

> We need to put more awareness out, even though it's out there, it’s not out there, let's say because in every state is different. I'm born and raised from New York. So for us there mental health, what it looks like, wasn't what it looks like here in Georgia, a lot of people are slowly coming to understand what depression looks like. And I think we need to put more awareness out, we need to be able to be everywhere, so people can know it's okay. And we're here to help; this place is to help them. One person that I had actually thought being mentally ill meant you had to be inpatient and put into what they he quote unquote, called a crazy house. That's not true. You know, it's a misconception of what mental health is, what it looks like, and what can happen from it. So I think, you know, we need to be more proactive, we need to get the word out that mental health doesn't make you crazy.

This education and increased awareness to reduce stigma is necessary for the public as well, including the families as well as the clients. This type of understanding also supports caregivers and family members in reporting behaviors and advocating for their family member. This was noted by Participant 3, who stated, “African American geriatric population can be effectively better diagnosed and treated when families are educated and caregivers continue to be their advocates."

Participant 3 continued to describe part of advocating is reporting caregiver observations that help the providers provide appropriate and timely care. This participant passionately described the need for caregivers to be willing to speak for the clients.

> This is a population that is easily forgotten and so caregivers have to care enough to observe the changes that are taking place in the individual and be willing to report what they observe to the pertinent medical practitioner for further follow up. … There has to be an educated and intentional understanding that these are people who once had an active life and have made their contribution to society. As such, they have feelings which they sometimes are unable to express, and therefore need our eyes, sensitivity, and willingness to advocate for them. (Participant 3)

Providing Ongoing Career Training. Participants in this study commonly cited the need for continued career training and professional development. This was noted to be important to self-awareness and bias, and toward not labelling clients. Participants called for self-awareness and bias training specifically.

> I just go back to my training in self-awareness. Um And just, I think it's the being aware that there's, you know, that there could be bias in the room. … I try not to approach any client with um how do I say this, each person is an individual, so I try not to, like, put labels on people to say, okay, this person, you know, has this,

> you know, is this race or from this particular culture, and they're going to absolutely feel this particular way. (Participant 1)

Participant 6 also described the need for ongoing training opportunities, as well as the significant impact of partnering with other clinicians as a strategy to support positive therapeutic outcomes and growth among therapists treating this population.

> I know, for the agency that I am with, I know that ongoing training opportunities, something that has been very helpful. Partnering with more seasoned clinicians, has also been very beneficial. Because I feel as though me being somewhat you know, although three years in, being somewhat new to the field. … I do feel that we don't have room for improvement, and we all have learning opportunities. And so I do remember being paired with more experienced clinician, I'm able to ask questions and new ways new research is being formed. So just really partnering, partnering with other professionals to really better effectively help our patients, I think that's one way that we could definitely sort of turn that curve. … I think that as time progresses, doing more research and really diving a little bit more into depression as a whole, as well as this population is something that I'm definitely interested in. And I can see myself furthering in this field for sure. And like I said, just partnering with other clinicians, that way I can be able to better understand the things that are changing within this field and learning more and more as I go.

This notion of partnering was also supported by participant 7, who described:

> I believe that working in a peer-to-peer approach where engagement was not singular, but group based. I have learned that working with African American

> communities, there is a "safety in numbers" rationale that often creates the safest space for other African American clients to share their challenges and be seen.

Opportunities for Engagement. Another theme in this category was that of the therapists' perceptions related to the need for increasing opportunities for engagement with this patient population. This theme aligns with prior themes related to the isolation among the patient population served and racial differences in engagement and activities offered. Participant 4 explained the need for additional activities and engagement, expressing the need for additional assistance in providing this engagement.

> I think more of what we're doing, I don't know what, you know, the back end of authorizations and money and all of that is, but you know, like I said, we're only there for an hour a week. So I don't know if there's something that we can do to train more facilities to have more engaging activities, or if there's some kind of way that we can have maybe more interns going more, going more often throughout the week. But there just needs to be more engagement. They're alone for so much. They're alone for so much of their day, that it becomes hard to be like, Okay, well, let me just do this for this hour. … Now, the facilities that I go to where there's back to back activities, so they might have bingo in the morning, and then drawing in the afternoon, and then music in the evening, those facilities much more engaged, much more happy residents. So I think if there was something that we can do as social workers to maybe train these facilities on the importance of those activities, maybe that will help or like something that, um, I don't know, taps into their families, like what's going on, why aren't y'all visiting

> them more often? They need that engagement, something like that, you know. (Participant 4)

Table 5 provides the related responses to best practice recommendations and the associated number of times the responses were offered within the interview transcripts.

Table 5

Best Practice Recommendations

Response	Number of times response was mentioned among the interview participants
Support less stigma	3
Partnering	3
Need for caregiver education	2
Caregivers need to report changes in behavior	2
Need more engagement	2
Match patient and therapist	1
Need caregivers to advocate for AA older adult patients	1
Need ongoing training opportunities	1
Need self-awareness/bias training	1
Not labelling people or have biases	1
Respect for the person	1
Use self-awareness/awareness of bias	1

Research Question 2

The second research question was: *How do social work practitioners who are providing care to African American geriatric patients diagnosed with depressive disorders describe their practices to improve retention and health outcomes among this population*? Practices to improve retention followed two main themes, one related specifically to the therapeutic approach taken, and the second related specifically to building trust and a sense of safety in the therapeutic relationship.

Building a Therapeutic Approach

The participants in this study recommended building a therapeutic approach using several key elements of respect, trust, and safety. A significant theme revealed from the analysis is the need to foster a sense of respect, safety, and trust in the therapeutic relationship. Participants discussed the importance of keeping the therapeutic relationship safe and helping the client feel safe in this relationship, in fact, feeling safe enough to disclose information in the therapeutic relationship. This requires trust building, although the participants noted that some will be more open than others.

Respect for the Person. The participants in this study described the need to have an ongoing acknowledgement and respect for the person and the therapist's role in treatment. This is probably best understood as described by Participant 4, who stated this respect is the "biggest" thing.

> I think that's the biggest thing. I think that, um, I will say, as much as I think depression impacts them, I think the biggest thing is recognizing that they still are a person and that they still have, you know, although a lot of them have depression, and you know, Alzheimer's or dementia, they still remember. And so our, our role is very important. They remember when you come in, and they remember when you engage with them, they remember when you're nice to them, and that I think impacts the way that their depression shows up. So I think if more people recognize that they're still in there that you know, we can support them more. (Participant 4)

Trust building and Feeling Safe. A second theme from the interviews related to the therapeutic relationship is building a relationship that is based on trust to allow the clients to feel safe, safe enough to disclose sensitive information and feelings, which may be more difficult to build based on race, as noted by Participant 1, who said:

> I just am aware that you know, especially with the, you know, advanced stage, I'm coming into, you know, coming into the therapeutic relationship, you know, there's a possibility I may have more work to do, you know, with, especially an African American male, as opposed to like, I was when I'm treating, you know, a white female, you know? And I'm just aware of that, and so there's, you know, I try to keep, keep the relationship safe. I try to, my goal, my goal is to help the client feel safe and secure. And it just starts by building trust, you know?

Participant 1 continued to describe the importance of keeping the therapeutic relationship safe for the client, in order to cross the barriers to disclosure by developing the relationship, creating a rapport with them, so that they feel safe enough to disclose important and personal information. Participant 1 stated, “[In the] therapeutic relationship, I think some of the barriers are just disclosure, um you know, just developing enough rapport with the client that they feel safe enough to disclose.” Table 6 provides responses offered related to developing and sustaining a safe therapeutic relationship.

Table 6

Developing and Maintaining a Safe Therapeutic Relationship

Response	Number of times response was mentioned among the interview participants
Help client feel safe	1
Safe enough to disclose information in therapeutic relationship	1
Trust building	1
Keep the relationship safe	1

Other key common elements mentioned by two participants in supporting a positive and effective therapeutic approach included (a) encouraging social activities to reduce feelings of isolation, which was noted to be a critical problem in the African American older adult population; (b) maintaining a focus on the grieving process; and perhaps most often noted, (c) the need to sit with patients without calling it therapy, sharing experiences and discussion. For example, these elements were all described by Participant 2 described the need to encourage social activities to reduce feelings of isolation, maintaining a focus on the grieving process (of clients), and sitting with patients without calling it "therapy." According to Participant 2, therapists need to "encourage a lot of social activities in nursing homes; encourage them not to isolate [themselves] … [and remain] focused on the grieving process."

Lastly, some essential recommendations from Participant 2 included the practice of simply sitting with patients to talk, without calling it "therapy." Participant 2 described this, stating:

> If you go and sit and be like, Hey, Miss James, how are you doing today? Oh, I'm good. And they'll tell you their life stories. … We're talking about the geriatric population, the African American geriatric population. Sometimes I don't use the word therapist. And I get a better welcome. Yeah, they're more welcoming. Hi, you know, I'm just here to sit and talk. If there's anything on your mind, you know, we can talk about anything you can tell me about. I make a little joke sometimes. You can tell me. I can see that you're a beautiful woman, I can just imagine how you were when you were younger. Tell me about your days, your fun days, and stuff like that, you know, sometimes that's a good opening.

With these strategies, the participant described a much greater acceptance rate and the ability to build trust with clients to support an enhanced therapeutic relationship, particularly among the African American older adult population on her caseload.

Summary

The data obtained for this study through the use of one-on-one interviews with social work therapists who treat depressive disorders among African American clients was analyzed using thematic analysis within the generic qualitative approach to reveal several themes from the data to provide a better understanding of the experiences of these therapists and to provide recommendations to inform practice. From the seven interviews, key themes were produced and used to describe the findings of the study according to the associated research questions of the study.

Addressing the first research question examining the experiences, challenges, and perceived best practices among social work practitioners who are providing care to

African American geriatric patients diagnosed with depressive disorders, the findings support a challenging impact of race with (a) cultural aversions to therapy, (b) the need for education and awareness to reduce the cultural aversion and improve acceptance the therapy; (c) racial differences in family engagement; (d) racial differences in terms of distrust, feelings of being dismissed, misdiagnosis; and (e) differences in activities and engagement based on race and socioeconomic status. Findings also supported a theme of the lack of empowerment among African American older adult clients with feelings of abandonment, and loss of autonomy to the point of using medication refusal as an empowerment tool. Recommendations for best practice included increasing awareness, reducing stigma, and the need for advocacy; the need for provision of ongoing career training for therapists; and the need for increased opportunities for engagement with the African American older adult population with depressive disorders.

Addressing the second research question examining how social work practitioners who are providing care to African American older adult patients diagnosed with depressive disorders describe their practices to improve retention and health outcomes, two key themes were revealed related to building a therapeutic relationship and approach. These themes included having and acknowledging respect for the patient as a person, and building trust and maintaining the feeling of being safe in the therapeutic relationship. This was accomplished in many ways, including not calling it therapy, but rather, simply promoting a conversation.

Section 4 will review the purpose and nature of the study and summarize and discuss the key findings of the study and how these findings can be used to inform social work practice. From this discussion, recommendations for future research and recommendations for practice moving forward are offered.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

Despite increasing rates and risks for depression and depressive disorders among African American older adult patients, this population remains significantly less likely to seek out, participate in, and remain in mental health services, resulting in poorer outcomes compared to their White counterparts (Conner et al., 2014; Davis et al., 2015; Huffman, 2020; SAMHSA, 2020; Taha et al., 2015). Research evidence supports the need for mental health practitioners to be more culturally aware (Dune et al., 2022; Vinson et al., 2014; Rice & Harris, 2021); however, a gap in the literature was identified as it relates to the perceptions and experiences of mental health professionals providing care to older adult African American clients with depressive disorders. Given the existing disparities, the purpose of this qualitative study was to explore the experiences and practices of social workers who are providing mental health care treatment to African American older adult patients (aged 65 and over) living with a depressive disorder in order to better understand the perspective of these social workers on the lack of retention and poor treatment outcomes and what changes can be made to practice that will support more effective treatment of this population. The study was designed to address the following research questions:

RQ1: What are the experiences, challenges, and perceived best practices among social work practitioners who are providing care to African American older adult patients diagnosed with depressive disorders?

RQ2: How do social work practitioners who are providing care to African American older adult patients diagnosed with depressive disorders describe their practices to improve retention and health outcomes among this population?

To address the gap in the research and the stated research questions, I used a generic qualitative design methodology (see Kahlke, 2018; Patton, 2015). Data were collected via seven one1:1 interviews with a purposeful, convenience sample of social work practitioners in Georgia to explore the experiences and perceptions of social work practitioners providing care to African American older adult patients experiencing depressive disorders.

In addressing the first research question examining the experiences, challenges, and perceived best practices among social work practitioners who are providing care to African American older adult patients diagnosed with depressive disorders, the findings support the negative impact of race in terms of cultural aversions to therapy; racial differences in family engagement; racial differences in terms of distrust, feelings of being dismissed, misdiagnosis; and differences in activities and engagement based on race and socioeconomic status. These factors were felt to have a negative impact on seeking, participating in, and remaining in therapy. Therefore, the social worker participants recognized the need for education and awareness to reduce stigma and the cultural aversion and improve acceptance the therapy.

Findings also supported a theme of the lack of empowerment among African American older adult clients with participants describing client feelings of abandonment, and loss of autonomy to the point of using medication refusal as an empowerment tool.

Recommendations for best practice included increasing awareness, reducing stigma, and supporting advocacy; providing ongoing career training for therapists/social workers; and increasing opportunities for engagement with the African American older adult population with depressive disorders.

Two key themes were revealed from the data to address the second research question examining how social work practitioners who are providing care to African American older adult patients diagnosed with depressive disorders describe their practices to improve retention and health outcomes. These themes included having and acknowledging respect for the patient as a person and building trust and maintaining the feeling of being safe in the therapeutic relationship, such as when participant one said, “I try to keep, keep the relationship safe. I try to, my goal, my goal is to help the client feel safe and secure. And it just starts by building trust, you know?” These themes both related to efforts to build an effective therapeutic relationship and an effective therapeutic approach.

This was accomplished in many ways, including not calling it therapy directly, but rather, simply promoting the time and relationship as conversational. These simple practices were felt to make a significant impact on participation. For example, when the second participant described, “Sometimes I don't use the word therapist. And I get a better welcome. Yeah, they're more welcoming. Hi, you know, I'm just here to sit and talk. If there's anything on your mind, you know, we can talk about anything you can tell me about.”

The findings of this study may serve to inform where the therapeutic relationship is breaking down, particularly as it relates to racial differences, and how to promote building a trusting relationship between the therapist and client, given these existing challenges serving to break down the relationship. The data from this study support that the ability to facilitate an open and trusting therapeutic relationship is critical to supporting the client feelings of safety that is required for them to share important but personal aspects of their experience related to and affecting their mental health. Adding this knowledge can support therapist strategies to developing stronger, more trusting therapeutic relationships that can bridge the cultural aversion and preexisting distrust.

Application to Professional Ethics in Social Work Practice

The findings of this study directly relate to several of the professional ethics in social work practice, as described in the NASW Code of Ethics. These include key ethical values of (a) social justice, wherein social workers challenge social injustice; (b) dignity and worth of the person, where social workers treat each person with care and respect, remaining mindful of individual differences and cultural and ethnic diversity; (c) the importance of human relationships, such that social workers recognize the central importance of human relationships; (d) integrity, supporting that social workers behave in a trustworthy manner; and (e) competence, as social workers strive to learn, grown, and educate themselves in terms of their knowledge and skills (NASW Code of Ethics, 2023). The findings of this study support the value of social justice and the ethical principle that social workers challenge social injustice.

The findings revealed perceptions of various negative racial and cultural impacts, including inequity in engagement activities based on race and/or socioeconomic status, a “support differential.”

> So, for example, when I was going to some of the nursing facilities that have more Caucasian residents, all kinds of activities, all kinds of people coming in and out, there's that support that’s there, and there’s that camaraderie around trying to get them out of that depressive state and get them engaged. Whereas with my African American facilities, or where there's primarily African American residents, you don't see that you don't see any activity. (Participant 4)

Identifying best practices and solutions to offset social norms that have resulted in aversion to participation in mental health services and poorer outcomes among African American older adult populations seeks to support social justice in a manner that promotes cultural respect, understanding, and competence, while supporting greater access to care. The data demonstrated the importance of trust in the therapeutic relationship, as critical to establishing a trusting rapport with clients, noted by Participant 1, who described, “my goal is to help the client feel safe and secure. And it just starts by building trust . . . just developing enough rapport with the client that they feel safe enough to disclose.”

When discussing the value of dignity of the person such that social workers not only treat clients with care and respect, but also remain mindful of individual differences and cultural and ethnic diversity, it is important to also discuss integrity, wherein the actions and behaviors of social workers support trustworthiness.

> I think the biggest thing is recognizing that they still are a person and that they still have, you know, although a lot of them have depression, and Alzheimer's or dementia, they still remember. And so our, our role is very important. They remember when you come in, and they remember when you engage with them, they remember when you're nice to them, and that I think impacts the way that their depression shows up. (Participant 4)

These values and ethical principles relate directly to the findings of this study demonstrating the need for understanding of the circumstances and perspectives of the client, and the need for educational awareness, destigmatization of therapy, and other measures on the part of the therapist to support trust in the therapeutic relationship. This also highlights the value of the importance of human relationships, as the ability to build a trusting therapeutic relationship is the key to successfully engaging clients in this population, engaging them as partners in the helping process. Lastly, the value of competence is identified as related to the findings of this study in that social workers should practice development and enhancement of the professional expertise. Sometimes, this may mean educating oneself on the experiences and perspectives of the client in order to better serve them.

Recommendations for Social Work Practice

The findings of this study support the negative impact of race, highlighting the effects of cultural aversions to therapy due to stigma, racial differences in family engagement, racial differences in feelings of distrust, feelings of being dismissed and misdiagnosed, and differences in activities and engagement based on race and socioeconomic status. Therapists need to be aware of these disparities and plan to address them early on, as these factors have an impact on seeking, participating in, and remaining in therapy. The most commonly noted was to address these issues of race was to build trusting relationships.

Among African American older adult clients with depressive disorder, the common feelings of abandonment and loss of autonomy cannot be ignored. Supporting clients' self-empowerment will be critical to ensuring the best care, as clients will use what they can to develop a sense of control, such as medication refusal. Increasing awareness and reducing stigma while supporting advocacy, professional development for therapists and social workers, and increasing engagement opportunities with older adult African American clients will help support client self-empowerment.

The research findings support the importance of relationship building in the therapeutic relationship to facilitate trust and comfort in the discussion of often stigmatized health issues. The facilitation of an open and trusting therapeutic relationship is critical to establishing feelings of safety that can break through cultural norms that support aversion to therapy. In practice, this means sometimes working around the name "therapy" and promoting the idea of just being conversational. Using conversational terminology rather than calling it therapy seemed to make a difference in acceptance and participation according to the participants in this study. Social work practitioners can use this strategy, particularly when working with clients that have high levels of perceived stigma around mental health, to support participation. Care center providers need to ensure engaging activities are offered to all clients and actively seek to reduce disparities in activities provided to clients. Policy at each care center needs to focus on equity in practice to ensure clients are all receiving the needed care, engagement, and opportunities for participation.

In my own social work practice, I will be integrating this conversational approach to providing services and toward building a relationship with the clients. The more they begin to trust me, the more likely the therapeutic relationship will support the level of participation needed for improved results. In addition, I will be promoting work on integrating more activities and engagement work with my African American older adult clients to ensure they are receiving engaging and diverse sets of activities that will promote improvements in mental health, participation, and self-empowerment. For example, I will be scheduling and facilitating nontraditional therapeutic activities such as “music night” where we play culturally specific music from various eras and use that as a tool to invite reminiscing. Also, I will be using scrapbooking activities to guide conversations and I will be labeling these conversations as “life reviews” to remove the label of therapy.

This study was limited to the perceptions and experiences of a small sample of therapists who work with African American older adult clients with depressive disorders within a limited geography. Therefore, although the findings of this study can shed light on areas of interest and potential strategies to support greater participation and retention of this population of clients in therapy, the findings are not generalizable to all populations of African American older adult clients with depressive disorders. In addition, the study was limited geographically to Georgia. It is possible that some regional norms related to mental health stigma could be stronger or less strong in different geographic areas. In addition, different approaches may or may not work depending on regional norms.

Additional research should be conducted on different strategies for building trusting relationships within the therapeutic relationship, particularly when the therapist does not share a culture or racial identity with the client. Research on programs aimed at increasing engagement and activities for African American older adult clients with depressive disorders as well as increasing awareness and reducing stigma associated with depressive disorders, as well as strategies to promote self-care and empowerment should be conducted to reveal effective strategies for reducing these limiting factors. Lastly, similar research should be conducted in different geographic locations to identify strategies that may be more universally effective or some that are more regionally accepted.

This research will be disseminated through publication on the University's research publication site. In addition, I plan to generate an abbreviated form of this research that I will submit for Journal publication. Lastly, participants in this study will receive a copy of the final research report.

Implications for Social Change

African American older adult clients with depressive disorders are less likely to participate in and remain in mental health treatment and therapy, but these clients may also be receiving less engaging care, may be fighting negative self-perceptions related to stigma and cultural perceptions related to care seeking, may feel abandoned and a loss of autonomy and personal empowerment and control over their diagnosis and treatment. These factors can be altered. Ensuring engaging activities for this population, using conversational approaches, making sure the client feels like they belong and have a sense of community because they have someone to talk to and activities to participate in will likely reduce feelings of abandonment, disengagement, and personal empowerment. Participating in their own care and their own wellness may be critical to personal health ownership, participation, and improved outcomes. By addressing these individual level changes, clients may have a sense of belonging and personal wellness control, shifting away from the disparities seen in outcomes among this population. The effect at the meso level is clear, as the reduction in stigma will support greater acceptance and improved therapeutic outcomes through the establishment of healing relationships as trust is developed and nurtured. Finally, at a macro level, program changes and educational opportunities to reduce stigma and support cultural awareness, both for therapists and clients, can help change attitudes around mental health services and participation, which can affect lives directly.

Summary

All people, regardless of age, race, sex, etc., deserve the opportunity to achieve wellness and mental wellbeing. As we age, depressive disorders can become common. Among African American older adult clients, the research continues to demonstrate lower participation and retention in mental health care, and as a result, poorer outcomes. Social workers can address distrust, low autonomy, low engagement, and the resultant low participation and poor outcomes by prioritizing the development of trusting therapeutic relationships utilizing conversational treatment plans that allow for the development of the relationship over time, while minimizing defensiveness due to preconceived notions of stigma. In addition, providing greater opportunities for engagement, regardless of socioeconomic status or race will be critical to achieving positive outcomes. Care centers need to have policies in place that will support equitable care for all.

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Appendix A: Initial Letter

Hello [name of potential participant],

I hope this note finds you well. I am a student in the Doctor of Social Work program at Walden University. As part of my Doctoral research, I am conducting interviews to understand social work practitioners' experiences treating African American geriatric mental health patients. I'm seeking practitioners in Georgia who are willing to participate in an interview for the study. Would you be interested in assisting my research?
The practice will include completing an Informed Consent statement (I will e-mail this to you); and allowing me to interview you in person, via Zoom call, or over a telephone call. The whole process should take no more than 60 minutes of your time.

Please let me know if you would like to participate. You can contact me by phone if you have any questions.

Sincerely

Sherian A. Sharomi
Sherian Sharomi, LCSW/ACHP-SW/CCATP/CCTHP/MSW/MSG
DSW Student
Walden University

Appendix B: Interview Questions

1. Please describe your journey to becoming a geriatric social worker and your goals and dreams related to your work in this role?
2. Tell me about your caseload in terms of demographic diversity of your patient population and variety of diagnoses.
3. Roughly what percent of your caseload consists of working with a diagnosis of depression among geriatric African American patients?
4. Can you describe your experience working with the African American geriatric population, both in general and in working with the diagnosis and treatment of depression among African American geriatric patients?
5. Using your experience, does race impact the diagnosis and treatment of depression in African American geriatric patients, and if so, can you describe how?
6. Have you experienced any challenges or barriers in diagnosing and treating African American geriatric patients with depression? If so, can you describe these challenges?
7. How do you think African American geriatric populations could be more effectively treated, particularly as it relates to depression and is there anything needed to do that?
8. Is there anything else you would like to share or expand on before we finish this interview?