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## **Assessing the Gender Differences in Mental Health Access and the Intersectionality of Depression, Anxiety, Stress between Black Men and Black Women during COVID-19**

Turquoise Ef'e Pipes  
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# Walden University

College of Social and Behavioral Health

This is to certify that the doctoral dissertation by

Turquoise E. Pipes-Purnell

has been found to be complete and satisfactory in all respects,  
and that any and all revisions required by  
the review committee have been made.

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2025

Abstract

Assessing the Gender Differences in Mental Health Access and the Intersectionality of  
Depression, Anxiety, Stress between Black Men and Black Women during COVID-19

by

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MS, Abilene Christian University, 2014

BS, Abilene Christian University, 2012

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

August 2025

## Abstract

The COVID-19 pandemic, which emerged in the past five years, has had a particularly severe impact on well-being, mental health, and access to care for Black communities. Therefore, the purpose of this quantitative study, grounded in intersectionality theory was to assess gender differences between Black women and Black men confronted with depression, anxiety, stress symptoms and mental health access during the crisis of COVID-19, which has been under researched within this demographic. The study sample included participants from various cities across the United States who lived through the COVID-19 pandemic from March 2020 to March 2023 (n= 104). A MANOVA analysis revealed no statistical significance by gender across DASS -21 subscales including depression, anxiety and stress symptoms. Wilks'  $\Lambda = .984$ ,  $F(3, 100) = 0.533$ ,  $p = .661$ , partial  $\eta^2 = .016$ . Another MANOVA analysis found that the multivariate effect of gender was not statistically significant across ten Barriers Mental Health Services Revised Scales, while the follow-up univariate analyses revealed two significant effects. Men reported higher stigma than women,  $F(1, 102) = 5.37$ ,  $p = .022$ , partial  $\eta^2 = .050$ , and greater concerns about psychotherapist qualifications compared to women,  $F(1, 102) = 6.55$ ,  $p = .012$ , partial  $\eta^2 = .060$ . These findings support the few previous results on the subject of intersectionality and gender and contains implications for reducing barriers and increasing access to mental health treatment for Black men and women. Lastly, this study also yields potential implications and guidance for mental health professionals and promotes positive social change in assisting these communities.

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## Dedication

I dedicate this research study to my grandmother, Betty Ann McLarty Hurd, whose love and comforting wisdom I still feel every single day.

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To begin with, I would like to express my deepest appreciation to my committee chair, Dr. Mita Johnson, for sharing her broad source of knowledge, weekly advice, ongoing encouragement, and content guidance throughout this dissertation process. I would also like to extend my thanks to my committee member, Dr. Patrice Bounds, for sharing her expertise and knowledge regarding the research process. This dissertation journey has allowed me to become a more critical thinker who has truly enhanced my academic and professional identity, and for this, I am grateful.

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## Chapter 1: Introduction to the Study

### **Introduction**

According to the Centers for Disease Control (CDC, 2024), COVID-19 (coronavirus disease 2019) is a disease caused by a virus named SARS-CoV-2. COVID-19 was found to be highly contagious and spread quickly. Over one million people have died from COVID-19 in the United States since it was first identified in 2019. Since the beginning of COVID-19, governments, businesses, and communities worldwide have been significantly impacted by the pandemic, resulting in millions of lives lost (Taylor, 2022). Five years after the pandemic developed, research continues to reveal and confirm the disproportionate impact and historic losses experienced within Black communities due to COVID-19 and its variants (Hu et al., 2022; Tan & Umamaheswar, 2022). This study will use the term “Black” when referring to Black, African American, or Black American individuals.

Research shows that while Black people make up approximately 13% (39,240,000) of the United States population, they are twice as likely to die from COVID-19 and three times more likely to be hospitalized compared to other ethnicities (Taylor, 2022). The question arises: Why are Black Americans disproportionately affected? Some research argues that systemic and structural racism create significant barriers to accessing equitable physical and mental health care services for Black people and other minorities (Saltzman et al., 2021). Mental health and access to quality care for Black people remain urgent concerns in U.S. society (Hannan et al., 2022). Reducing biased treatment from mental health professionals and maintaining the profession’s value for multicultural competence and clinical care is crucial.

### **Background**

The COVID-19 pandemic, which emerged in 2020, has had a particularly severe impact on well-being, mental health, and access to care for Black communities (Okoro et al.,

2022). Historical accounts of racial trauma, economic injustice, and social-cultural inadequacies have shown that Black communities are unequally affected by public health crises and disasters. Past instances include higher rates of negative health outcomes during the HIV/AIDS epidemic, more depressive symptoms after Hurricane IKE, and greater trauma and anxiety after Hurricane Katrina (Taylor et al., 2022; Novacek et al., 2020). There is a scarcity of information on psychological distress and coping strategies among Black populations during the COVID-19 pandemic.

### **Problem Statement**

Black people represent approximately 12% (39,240,000) of the U.S. population but account for 19% (62,130,000) of individuals struggling with mental health challenges. They also reportedly died at disproportionately higher rates from COVID-19. Systemic and structural racism create barriers to equitable health care services. This study seeks to understand the intersection of gender differences and mental health disparities between Black women and Black men during COVID-19. We must understand these intersections to bring equitable mental health care to Black communities.

### **Purpose of the Study**

The purpose of this quantitative study was to explore gender differences between Black women and Black men confronted with mental health concerns during the COVID-19 pandemic. The study aimed to understand differences in access to mental health care when gender and race/ethnicity intersect during a crisis. The goal was to enhance the knowledge of counselor educators and mental health professionals, increasing their understanding of perceived barriers and providing advocacy for better mental health care for this population.

## **Research Questions and Hypotheses**

### **Research Questions**

RQ1: Do the intersecting variables of gender identification and mental health concerns (specifically depression and anxiety) differ between Black women and men during the COVID-19 health crisis?

RQ2: Are there differences between how Black women and men accessed mental health care when gender and race/ethnicity intersected during the COVID-19 health crisis?

### **Hypotheses**

H1: There are gender differences between Black women and Black men in accessing mental health care during a health crisis like COVID-19. Additionally, there are significant differences in mental health concerns like depression and anxiety.

H0: There are no gender differences between Black women and Black men in accessing mental health care during a health crisis like COVID-19. Additionally, there are no differences in mental health concerns like depression and anxiety.

### **Theoretical Framework for the Study**

This study is rooted in intersectionality theory, which considers individual experiences within larger social contexts. Etherington et al. (2020) emphasized that intersectionality is a theoretical framework

that is frequently identified as an important theoretical framework for health research.

Known as a central theoretical concept and social justice framework, intersectionality provides a way to consider individual experiences within larger social contexts, highlighting how various intersections structure our everyday lives and interaction. (p. 2).

Intersectionality, developed from critical race theory, acknowledges that a person's experiences can change over time and that multiple identities (e.g., ethnicity, gender,

socioeconomic status) intersect to shape these experiences (Tinner et al., 2024). This framework is crucial for understanding the disparities in mental health and access to care among Black communities during COVID-19.

Research has clearly demonstrated the significant disparity in loss of life expectancy due to COVID-19 over the past 2-3 years, with a 3.1-year loss in the Hispanic community and a 2.1-year loss in the Black population (Alex et al., 2021). Millet et al. (2020) analyzed county-level data from the United States Bureau American Community Survey, comparing counties with higher and lower populations of Black people. They found that nearly 90% of counties with higher proportions of Black residents reported a confirmed COVID-19 case, and 49% reported a death, versus 81% and 28% in all other counties. Generally, areas with higher levels of Black residents experienced more COVID-19 diagnoses. The question arises: why is this the case?

This study will highlight the conceptual understanding of intersectionality, developed in 1989 by Kimberlé Crenshaw, which describes how identities such as gender and race can impact the lives of marginalized individuals (Crenshaw, 1991). Crenshaw defined intersectionality as “a lens, a prism for seeing the way in which various forms of inequality often operate together to exacerbate each other” (Steinmetz, 2020). Brownlow et al. (2019) further explained that intersectionality can expose the inadequacies of a single-axis framework and acknowledged that more intersectional research is needed to examine the multiple dimensions that impact Black women and men. Tarshis and Baird (2021) posited that intersectionality, a critical social theory, originated from the Black feminist organization Combahee River Collective in the 1970s. Activist movements and intersectionality scholars such as Angela Davis, Gloria Anzaldúa, and Cherríe Moraga have utilized the term. Moradi et al. (2021) suggested that Crenshaw (1989) and Collins (1999-2000) advanced

intersectionality into a scholarly groundwork of reference that has now progressed as “a field of study, analytical strategic tool, and critical praxis for social justice” (p. 152).

Currently, the intersection of the COVID-19 pandemic with mental health care and gender differences within the Black population has rarely been studied. Therefore, the aim of this study is to expand the intersectional framework not only of what intersectionality is but, more importantly, what it does through examining within-group differences and the ways in which mental health, gender, and events like the COVID-19 pandemic are woven into the fabric of intersectionality research. This is now becoming an important component in addressing the poor physical and mental health inequities in Black neighborhoods across the United States (Liu & Modir, 2020).

This research utilizes a correlational design. Fitzgerald et al. (2004) noted that the primary importance of correlational designs is that they allow the relationships between variables to be examined without manipulation. The relationship variables presented in this research include a criterion variable (dependent variable) being predicted and two predictor variables (independent variables).

### **Nature of the Study**

This quantitative study employed a correlational design involving Black women and men who contracted COVID-19 from March 2020 to March 2023. Participants will be recruited through the National Community Health Centers to participate in an online survey. The study will focus on gender differences in mental health concerns like depression and anxiety, and access to mental health care during COVID-19. Fitzgerald et al. (2004) noted that the primary importance of correlational designs is that they allow the relationships between variables to be examined without being manipulated. The relationship variables presented in this research include a criterion variable (dependent variable) or the variable being predicted, as well as two predictor variables (independent variables).

This study focuses on exploring potential gender differences between Black women and Black men in accessing mental health care during the COVID-19 pandemic. Using a quantitative approach, I examine how intersecting identities of gender and mental health concerns manifest differently among Black women and men during health crises such as COVID-19. The study also investigates disparities in access to mental health care by exploring how gender intersects with race/ethnicity during such crises. Adopting an intersectionality lens in this quantitative design enables a broader understanding of these disparities for Black women and men. Intersectionality theory, first introduced by Kimberlé Crenshaw, provides the theoretical framework for this study, emphasizing how various systems, including race, health, and gender, intersect (Scarborough et al., 2021). Scholars have supported intersectionality in exploring differences within and among groups (Kelly et al., 2022). The study employs a correlational design to examine relationships between variables without implying causation, assessing statistical associations between dependent and independent variables (Scarborough et al., 2021; Seeram, 2019).

### **Definitions**

*Anxiety:* Anxiety involves an apprehensive anticipation of some future threat that results in feelings of unease and a sense that things are uncontrollable or unpredictable (Wall & Lee, 2022).

*Black or African American:* “Black or African American” refers to individuals with origins in any Black racial group from Africa (CDC, 2022). As of 2021, Black people constituted 12.1% of the United States population, totaling approximately 40.1 million individuals. This demographic ranked Black people as the second-largest racial group in the United States at the time of this study (Office of Minority Health, 2021).

*Depression:* A negative affective state, ranging from unhappiness and discontent to an extreme feeling of sadness, pessimism, and despondency, that interferes with daily life.

Various physical, cognitive, and social changes also tend to co-occur, including altered eating or sleeping habits, lack of energy or motivation, difficulty concentrating or making decisions, and withdrawal from social activities. It is symptomatic of several mental health disorders. (American Psychology Association. n.d.).

*Intersectionality:* Intersectionality refers to a “lens” or “prism” that focuses on a perspective through which various forms of inequality often interact to mutually reinforce each other (Steinmetz, 2020).

*COVID-19:* COVID-19, known scientifically as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), emerged as a suspected syndrome originating from Wuhan, China, in 2019, possibly transmitted from animals to humans (Kumar, 2021).

*Gender:* **Gender** is comprised of socially constructed roles, behaviors, and expressions, and can influence how individuals experience their physical body, recognize themselves, and determine how resources are disseminated in societies (Rebel et al, 2023).

*Mental Health:* The emotional, psychological, and social well-being that impacts how we think and feel and helps determine how we manage stress, relate to others, and make choices (Substance Abuse and Mental Health Services Administration, 2023).

*Mental Health Disparities:* The power that imbalances that impact practices influencing access, quality, and outcomes of behavioral health or significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rate in a specific group of people defined along racial or ethnic lines, as compared with the general population (Substance Abuse and Mental Health Services Administration, 2023).

*Gender Identification:* A personal impression of an individual’s hold of their own gender is a vital component in comprehending human behavior (Choi & Merlo, 2021).

Gilbert et al. (2016) argue that the definition of gender identity refers to “beliefs and

behaviors that are practiced in social interactions and therefore are able to vary among individual cultures” (p. 301).

*Race Related Stress*: Transitions between individuals or groups and their environment that emerge from the dynamics of racism, and that are perceived to tax or exceed existing individual and collective resources or threaten well-being (Cokley et al, 2022).

### **Assumptions**

Communities of color, particularly Black communities, have faced disproportionate impacts from COVID-19 (Taylor, 2021). Studies indicate that although Black Americans make up approximately 12% (39,240,000) of the U.S. population, they represent at least 19% (62,130,000) of individuals dealing with mental health challenges (Onwumere et al., 2023). Onwumere et al. also highlight a rising prevalence of mental health conditions in Black communities, coupled with significant barriers to accessing quality care. Salzman et al. (2021) report that only 31% of Black Americans seek mental health treatment compared to 48% of White Americans. They attribute these disparities to social determinants such as race, ethnicity, inequalities in health coverage, stigma surrounding mental health, limited access to providers, and socioeconomic status.

Additionally, Gallagher et al. (2021) discuss research by Bruce McEwen, proposing that allostatic load theory may explain pervasive health disparities among Black women and men. This theory suggests that cumulative stressors like inadequate healthcare access, substandard housing, food insecurity, and racism contribute to a “wear and tear” effect on health within Black communities. While some studies have examined mental health among Black individuals, there is a notable scarcity of research addressing the intersection of the COVID-19 pandemic with mental health care, race, and gender differences within Black communities, specifically focusing on Black women and men. This study assumes that Black men would report more positive attitudes towards receiving improved mental health care if

they were of a different race or ethnicity compared to Black women during COVID-19. Additionally, it predicts that levels of depression and anxiety among Black women seeking mental health care during COVID-19 would be lower than those among Black men.

### **Scope and Delimitations**

This literature review sourced keywords from multiple databases accessible through Walden University, including OASIS, ProQuest, JSTOR, Google Scholar, and EBSCOhost. I employed specific keywords corresponding to different sections of the literature review to identify relevant information for the study. The keywords utilized were intersectionality, COVID-19, health crisis, mental health care, health disparities, access to mental health, barriers to treatment, Black women, and Black men. Participants in this research are limited to Black women and men aged 18 and above, with origins in any Black racial group from Africa residing in the United States of America.

### **Limitations**

Potential challenges of this study include difficulties in recruiting a sufficient number of eligible participants for the survey. Another challenge is selecting the most suitable instruments to measure both the dependent and independent variables necessary for data collection. Additionally, a limitation of this study would be the ability to generalize the findings based on the participants' geographic locations.

### **Significance**

The existing literature has extensively documented disparities in Black Americans' access to mental health care, particularly evident during and post-COVID-19. However, there is a notable gap in research focusing on gender differences between Black women and Black men facing mental health challenges during health crises like COVID-19. Structural and systemic racism are acknowledged as significant barriers to accessing necessary mental health care, but understanding the additional barriers posed by gender differences is crucial

for the next generation of mental health clinicians and counselor educators. This study has significance because it addresses how factors such as race, gender, disparities in mental health care, and health crises impact communities of color, which are critical issues facing future clinicians.

### **Summary**

Chapter 1 of this research proposal, presented here, introduced the background information, problem statement, purpose of the study, research questions, definitions of terms, scope, limitations, and potential challenges. In the next chapter, the literature review explores the problem and what we know to date. This includes information from current research studies, highlighting gaps in the research. The gaps noted in this proposal underscore the importance of studying gender differences and the intersectionality of mental health disparities with barriers experienced by Black women and men during COVID-19.

## Chapter 2: Literature Review

### Introduction

Assessing the mental health concerns and intersecting identities of gender among Black women and men during the COVID-19 health crisis has been significantly underexplored in research. The few existing studies highlight that Black communities have experienced higher rates of infection and mortality due to COVID-19. However, there is a gap in comparing the mental health concerns and perceived differences between Black women and men, particularly when ethnicity intersects with access to mental health care during COVID-19. This quantitative study highlighted the gender differences within the Black community regarding mental health concerns and explored how the COVID-19 health crisis impacts access to mental health care in relation to ethnicity.

The COVID-19 pandemic has had a devastating impact on global health and social structures. Among marginalized communities, Black women and men have been disproportionately affected, experiencing infection and mortality rates 2-3 times higher than those of other ethnicities (Cunningham-Erves et al., 2022). Recent studies indicate that the pandemic has led to an increase in depression and anxiety symptoms among adults across the United States (Nagata et al., 2022). Pre-pandemic research in Canada found that more than half of Black respondents suffered from anxiety, depression, and PTSD symptoms. Another study found greater mental health concerns and heightened feelings of racial discrimination among Black individuals who experienced COVID-19. Summers et al. (2022) noted that, while Black women and men report more severe mental health distress compared to the majority population, their mental health needs remain underexplored.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP 2024) standards recognize the importance of addressing social and cultural identities and experiences in counseling. They emphasize the role of counseling educators in

promoting multicultural counseling models and developing strategies to identify and eliminate barriers and prejudices, ultimately aiming to improve mental health and wellness for all individuals.

Therefore, an important aspect of this study will include an advocacy and social justice component, emphasizing the need for multicultural competence and cultural sensitivity among counselor educators and other mental health professionals when working with this unique population. This chapter will explore the intersectionality of gender identification and mental health concerns, specifically depression and anxiety, among Black women and men, and examine access to mental health care during the COVID-19 pandemic. In addition to providing an in-depth review of current and previous research, this chapter details the search engines used to discover relevant literature. Other key areas of focus include a discussion on the theoretical framework that provides a guiding lens and pathway of support for this study, a review of measured variables and their correlations, and a comprehensive analysis of the primary literature presented.

### **Literature Research Strategy**

In order to further understand the past and present literature on gender differences in how Black women and men accessed mental health care during COVID-19, a search strategy was initiated. The robust search of databases that were utilized included: Pro Quest Central, APA Psyc ARTICLES, Google Scholar, SAGE Journals, APA Psych Books, MEDLINE, PubMed, ScienceDirect, Taylor and Francis Online, Library Multi- Database, and Health and Psychosocial Instruments. Related key word phrases that were utilized in the data base search included *gender identification, COVID-19, Black, African American, health crisis, pandemic, mental health services, intersectionality, mental health treatment, Black Mental Health, cultural mistrust, Black communities, race, structural racism, depression, anxiety, stress, mental health concerns, access to mental health, disparities, race related stressors, mental*

*health disparities, and access to care.* The search engines that were employed to review related key words were Google Scholar and Walden University library.

### **Literature Review Related to Key Variables and/or Concepts**

#### **Black Communities in the United States**

Black Americans experience mental health conditions at rates similar to the rates for the general population. The Centers for Disease Control (CDC, 2024) recognizes racism to be a significant threat to public health, particularly impacting communities of color by increasing the risk of poor health outcomes. When examining the mental well-being of Black Americans, it is crucial to consider their experiences within a historical and cultural context. The Black community has demonstrated remarkable resilience in the face of adversity spanning numerous centuries.

Beginning in the 1600s, Black individuals were oppressed as a group through the enslavement of Africans and their descendants, leading to profound and long-lasting effects on people of African descent. The impact of considering a group of individuals as property rather than human beings cannot be overstated; the impact can cause epigenetic changes to the human genome. Up until 1965, U.S. laws were utilized to justify the mistreatment of Black individuals. Following the American Civil War, Black people encountered oppression in the form of sharecropping, which severely limited their economic mobility, as well as enforced and legalized segregation from housing, healthcare, and other essential services.

Although modern-day racism may be less overt, it still is perilous, manifesting in restricted access to housing, healthcare, education, and heightened rates of incarceration. The enduring social, economic, and emotional burdens persist for Black Americans. Pew Research (2024) found that while black communities are disseminated across many areas within the United States of America, over 50 percent of the Black population are currently concentrated and reside in the southern sections of the United States in a mix of urban,

suburban, and rural communities. Poteat et al (2020) further discussed how the well-being and social inequities of Black Americans living in communities have been negatively affected by greater rates of heart disease, diabetes, HIV and lack of insurance or access to care which increases poor health outcomes.

### **Gender Identification**

Gender identification has significance for new clinicians when exploring the intersectionality of gender and mental health access. Few studies have examined the intersection of gender identification differences between Black women and Black men, their mental health concerns, and a health crisis like COVID-19. Existing research has evaluated gender differences in relation to physical health, consultations with health professionals, emotions such as fear, sexual activity, and experiences of racial discrimination. For instance, one study suggests that women seek out mental health professionals more frequently than men, whereas men may be more willing to seek services based on specific provider credentials (Cox, 2014).

Staton et al. (2022) found that Black women positively associate body image concerns with depressive symptoms. Choi and Merlo (2021) reported that individuals identifying as male or perceiving themselves as masculine were more likely to suppress fear, which negatively impacted their ability to access services. In contrast, women were more likely to seek services due to fear. This study explained that these men “do gender” through “a complex of perceptual, interactional, and micropolitical activities that cast particular pursuits as expressions of masculine and feminine natures,” leading them to suppress fear, while women were more forthcoming about being afraid (p. 130).

Gilbert et al. (2016) discussed an intersectionality-gendered framework aimed at improving the health of Black men and reducing race and gender disparities in health. Brownlow et al. (2019) argued that several studies on gender identification have suggested

some gender differences, noting that Black women reported experiencing less racial discrimination than Black men. Assari et al. (2017) found that over time, Black men experienced increased negative psychological effects from racial discrimination compared to Black women, who reported more microaggressions and personal insults rather than direct acts of discrimination. However, the literature remains extremely limited on the exclusive focus of within-subject gender differences between Black women and Black men when impacted by a health crisis like COVID-19.

### **Race and Racism**

According to the National Human Genome Research Institute (NHGRI, 2024), race is a political and social construct used to group people. It was constructed as a hierarchal human grouping system, generating racial classifications to identify, distinguish, and marginalize groups across nations, regions, and the world. Race divides human populations into groups, often based on physical appearance, social factors, and cultural backgrounds. Race is a culturally structured, systematic definition of a way of perceiving and interpreting reality.

Race has been used historically to set up a social hierarchy whereby individuals are treated differently, resulting in racism. The American Psychological Association (APA, 2024) has defined racism as a form of prejudice that generally includes negative emotional reactions to members of a group, acceptance of negative stereotypes, and racial discrimination against individuals; in some cases, it leads to exclusion and avoidance. In the United States, the identification and addressing of racism in its various forms are crucial aspects of understanding the detrimental impact of racism on marginalized communities, particularly Black women and men (Rattani, 2021). According to Medlock et al. (2019), career fields in psychology and psychiatry have historically contributed to perpetuating systems of oppression, including racism. Williams et al. (2019) contended that race is a social construct built on ethnicity, nationality, phenotype, and other social differences that influence

access to power within a society. Evans et al. (2021) proposed that racism operates on multiple levels and within various platforms, including individual internalized racism, interpersonal racism, institutional racism, and structural racism.

Adkins-Jackson and Rodriguez (2022) suggested that individual internalized racism involves individuals and communities adopting negative messages, images, and beliefs about their own nature, ability, and worth, as well as those who resemble them (726). This can manifest as individuals agreeing with stereotypes or prejudiced beliefs about their own ethnicity being inferior to the majority racial group (Gale et al., 2020). In his book *'The Souls of Black Folk,'* W.E.B. Du Bois referred to this phenomenon as 'double consciousness,' where individuals feel like they are constantly evaluating themselves through the eyes of others, based on a world that views them with amused contempt and pity (Du Bois, 2008).

Interpersonal racism, or personally mediated racism, is defined as the imposition of prejudicial and ethnocentric beliefs on individuals and communities in the form of discriminatory actions (Evans et al, 2021). The American Psychological Association further explains that interpersonal racism occurs when behaviors of the dominant racial group diminish and harm members of other racially marginalized groups (APA, 2021, p. 2). Examples of interpersonal racism include microaggressions and the 1921 Tulsa Race Massacre, where a white collective destroyed a prosperous African American community in the Greenwood neighborhood, also known as 'Black Wall Street,' resulting in the deaths of 300 African Americans and leaving 10,000 homeless due to the burning of 40 blocks in Tulsa, Oklahoma (Swanson, 2022).

### **Race Related Stressors in Black Community**

Recent studies acknowledge that members of the Black community express the greatest level of race related stressors when compared to other ethnic groups (Holloway & Varner, 2021). Researchers acknowledged that these stressors could stem from both direct

and indirect situations of racism that could involve personal, vicarious, or anticipated racial discrimination (Holloway & Varner, 2021; Byers et al, 2021). According to Holloway and Varner (2021)

Vicarious racial discrimination involves “witnessing or hearing about another individual’s racial discrimination”; while anticipated racial discrimination involves “fearing that one may be discriminated in the future”. (p. 603)

Researchers of Emory University (2023) noted that additional risks of race related stress including the feeling of being belittled, degraded or ridiculed may be associated with unfavorable mental health outcomes such as PTSD and depression symptoms among Black individuals (Cockley et al, 2022).

Mekawi et al (2024) described four categories of race related stressors including individual racism involving communication with other people, institutional racism which includes the discrimination of a race that is supported within policy institutions; cultural racism that subscribes to the notion that one race is more elevated than another. The last category involves collective racism in which corporate groups or organized parties seek to diminish the rights of Black people. One study examined the impact of race related stress with pregnant Black mothers and found that after justifying for differences in diet, social economic status and smoking that elevated exposure to race related stress in particular was connected to higher cortisol reactivity in the pregnant Black mothers as well as with their children a year later, higher rates of preterm labor, and significant risk factor other primary health and other psychological disorders (Hendrix et al. 2022).

In other existing research, Simons et al. (2018) discussed the work of Geronimus (2006) who coined the phrase “The weathering Hypothesis” which suggest from his study that health disparities experienced by Black people stem from a “physiological response to the structural barriers and daily slights, stereotypes, and other threats to one’s identity that

compromise the Black experience” (p. 1994). Forde et al (2019) added that the unfavorable physiological response of weathering experienced on black bodies is said to advance “the normal aging process and earlier onset of deteriorating health conditions among disadvantaged as well as advantaged individuals of similar age” (p. 1). Although a growing body of research concerning race related factors are becoming well known in literature, there continues to be gap in research that examines within group differences between Black women and men and race related stresses specifically.

### **Structural Racism and COVID-19**

Institutional and systematic racism has been suggested by some researchers to be deeply ingrained in the COVID-19 crisis, contributing significantly to the disproportionate death of black individuals (Bioethics, 2022). In the United States, structural racism has played a significant role in shaping both current and historical events, leading to notable disparities within the Black community. This form of racism creates avoidable and unfair inequities in access to power, resources, and opportunities for minority groups considered inferior in the context of White supremacy (Misra et al, 2022; p. 625). According to Hu et al (2022), structural racism encompasses institutional policies and practices that influence opportunities and can result in discrimination in areas such as employment, education, housing, and other determinants of health (p. 1).

Similarly, Estrada et al (2022) defined structural racism as “the promotion of mutually reinforcing inequitable systems that perpetuate discriminatory beliefs, values, and resource distribution” (p. 367). This concept implies the existence of prejudiced laws, rules, and regulations specifically targeting marginalized communities. Tan and Umamaheswar (2022) argued that the high rates of injury and death from COVID-19 experienced in Black communities reflect the deteriorating systems that significantly amplify disparities in marginalized neighborhoods. Furthermore, other researchers have highlighted the historic

roots, embedded systematic issues, and inequities affecting Black women and men across the United States since its inception (Adam & Welsh, 2009; Makematic (Producer), 2020; Buck, 2017; Adam & Welsh, 2009).

### **A Framework for Intersectionality**

Recent research has highlighted the significant disparity in life expectancy loss among communities of color due to COVID-19, with a 3.1-year reduction in the Hispanic community and a 2.1-year reduction in the Black population (Alex et al., 2021). Millet et al. (2020) analyzed counties with varying Black populations to determine if COVID-19 diagnoses and deaths were more prevalent in areas with larger Black populations. They found that nearly 90% of predominantly Black counties reported a confirmed case, and 49% reported a death, compared to 81% and 28% in all other counties, respectively. This study revealed that areas with higher Black populations experienced more COVID-19 diagnoses, raising questions about the underlying causes.

This current study utilized the framework of intersectionality theory, developed by Kimberlé Crenshaw in 1989, which describes how multiple forces such as gender, race, and class intersect in the lives of marginalized individuals (Crenshaw, 1991). Born from Critical Race Theory, intersectionality exposes the inadequacies of a single-axis framework and emphasizes the need to examine multiple dimensions that impact Black women and men (Brownlow et al., 2019). Tarshis and Baird (2021) noted that intersectionality, rooted in Black feminism, has been used by activists and scholars like Angela Davis, Gloria Anzaldúa, bell hooks, and Cherríe Moraga. Moradi et al. (2021) suggested that Crenshaw (1989) and Collins (1999-2000) elevated intersectionality into a scholarly framework, serving as an analytical tool and critical praxis for social justice.

Gilbert et al. (2016) proposed that while intersectionality has traditionally explained the lived experiences of Black women, it can also be applied to Black men's experiences,

given their shared victimization from the intersection of race, gender, and health. Collins et al. (2022) conducted an extensive study on young adult Black men and argued that research has generally overlooked the mental health conditions of Black men. They advocated for using an intersectionality framework to assess how gender, race, and social caste impact mental health.

### **Health Crises**

Several scholars have examined crisis management for clinicians and offered that a healthcare crisis signifies a pivotal moment in disease progression, determining whether an individual will move toward recovery or death. Linsk (1993) defined a healthcare crisis as a “progressive and massive rise in costs coupled with a failure to provide care to a large minority of the population.” Past health crises experienced globally in recent years include Ebola, SARS, Monkeypox, and, most recently, the Coronavirus.

The Ebola RNA virus, also known as Ebola hemorrhagic fever, began its outbreak in Guinea, Africa, in December 2013. Researchers reported that the transmission originated from consuming wild animals, including antelope and monkeys. Ebola is transmitted to humans through bodily fluids such as blood, saliva, or stool. Symptoms include high-grade fever, chills, vomiting, organ failure, internal bleeding, and sepsis, leading to a 50% mortality rate among infected individuals. Ebola has spread to several areas in Africa, including Liberia, Senegal, Sierra Leone, Nigeria, and other regions, including Spain and the United States (Dawson, 2015; Donovan, 2014).

Monkeypox, also known as Mpox, is rarely deadly but still a devastating disease caused by the variola virus. It was first identified in 1958 in Denmark, with the first human case recognized in 1970 in East, Central, and West Africa. Symptoms of Mpox include a painful skin rash and lesions on the body’s extremities, such as the hands and feet, as well as on the face and chest. Other symptoms include fever, chills, fatigue, swollen lymph nodes,

and respiratory symptoms. The World Health Organization (WHO, 2023) reported that Mpox can be transmitted from person to person through contact with an infected wild animal or human-to-human contact. In 2022, Mpox reappeared and quickly spread globally, affecting 110 countries across Europe and the Americas. As of December 2023, there have been 92,432 confirmed Mpox cases and 170 reported deaths (WHO, 2023).

Severe Acute Respiratory Syndrome (SARS) was identified by the WHO in February 2003. SARS is caused by a coronavirus that began in Asia and spread to two dozen countries, including North America, Europe, and South America. Symptoms include muscle pain, headaches, fever, shortness of breath, and a dry cough. Although only eight people in the United States were diagnosed with SARS, the WHO reported a total of 8,098 infections worldwide, with 774 deaths (WHO, 2023; Centers for Disease Control, 2017).

The most recent and well-known health crisis is the Coronavirus, COVID-19. COVID-19 qualifies as a healthcare crisis because the threat to public health, our economy and our way of life is eminent (AMA, 2020). COVID-19 was declared a public health emergency by the World Health Organization (WHO) on January 30, 2020. As of January 31, 2023, there have been 753,479,439 confirmed cases of COVID-19 and 6,812,798 total deaths globally (WHO, 2023; Cui & Han, 2022). COVID-19 is caused by the SARS-CoV-2 virus, which belongs to the Coronaviridae family and the genus Beta coronavirus. The term “corona” comes from the Latin word for “halo” or “crown,” referring to the virus’s appearance (Kumar, 2021). Researchers suspect that SARS-CoV-2 originated from Wuhan, China, and was possibly transmitted from animals to humans in 2019. The disease spreads rapidly through respiratory droplets and close contact. As of the fall of 2022, COVID-19 has affected more than 200 countries, with over 612 million confirmed cases and 6.5 million deaths globally, including over one million deaths in the United States (Johns Hopkins Resource Center, 2022).

## **Health Crisis and COVID-19 in Black Communities**

COVID-19 spread rapidly across the United States, but its impact was not uniform across all populations (Egan et al., 2022). Research found that Black people, who make up 13.4% of the U.S. population, were overrepresented in hospitalizations, accounting for 40% of such cases. Black people were hospitalized with COVID-19 at nearly three times their population size, the only ethnicity with rates above their population proportion (Gaynor et al., 2020). Another national study reported that for every 1% increase in the Black population, there was at least a 2.12% surge in COVID-19 mortalities (Bogan et al., 2021).

Certain regions reported even more concerning data. For example, in Louisiana, 70% of COVID-19 deaths were among Black people, who only make up 33% of the population. Similarly, in Alabama, the Black population accounted for 44% of deaths while comprising only 26% of the population (Kemp et al., 2021). Lancelot suggested that these disparities are rooted in social inequities, including decades of racial oppression and civil and human rights violations, which have exacerbated structural inequities in Black communities. Don et al. (2023) identified mental health as a global crisis, with prevalence levels higher than cancer diagnoses. The WHO reported that the COVID-19 pandemic increased the prevalence of depression and anxiety by 25% worldwide, highlighting the pandemic's significant impact on mental health.

## **Black Mental Health**

Mental health is described as a vital component essential to an individual's well-being, impacting their capacity to mitigate stress or build connections, and is viewed as a basic human right for all (World Health Organization, 2022). Walker (2020) argues that the state of Black mental health is plummeting due to an epidemic of ignored stress and denied pain that has gone unchecked for too long. Collins et al. (2022) similarly acknowledge that Black Americans continually face various stressors due to past and present sociocultural

factors, resulting in depression and anxiety symptoms despite research reporting that the Black community is less likely to be diagnosed with depression or anxiety compared to White individuals. In the United States, at least one in five individuals are diagnosed with a mental health disorder (SAMHSA, 2022).

In 2020, Joseph et al. (2024) pointed out that 17% of Black adults self-disclosed being diagnosed with a mental health disorder, and some researchers suggest that Black people consistently report higher symptoms of depression, stress, and mental disturbance. Goldbolt et al. (2022) suggested that one of the many sources of stress for Black women involves carrying the stereotyped label of “The Strong Black Woman” (SBW). The root of this “syndrome” stems from the idea that Black women have no option but to be audacious and industrious and remain unbreakable physically, mentally, and emotionally despite societal burdens of racism and exploitation. This stereotype ranges from the physical and sexual abuse and mistreatment during the slavery era to the lawful “reproductive exploitation for economic gain,” exemplified by the case of Henrietta Lacks (Goldbolt et al., 2022, p. 609).

Watkins et al. (2022) conducted a study on Black men and their mental health, reporting that a cumulative amount of social, cultural, and psychosocial stressors and structural barriers increases mental health distress among this population. A significant source of stress for Black men is the expectation to adhere to hegemonic masculine norms, such as not showing weakness or being perceived as dangerous due to their size or dark skin color. These masculine norms contribute to the mental health challenges faced by Black men, exacerbating their stress and anxiety (Watkins et al., 2022).

### **Depression and Anxiety in Black Communities**

The World Health organization identified depression as a prominent health condition in 2020 and suggests that by 2030, depression will be recognized as the leading health concern affecting people globally (Hanner -Walker, 2020). While clinical depression is

widespread within the United States, the condition is frequently left untreated or misdiagnosed (Bailey et al, 2019). Black individuals again make up 13% of the population as noted within this research study in the United States and yet statistics recognizes that 20% of that Black population are disproportionately living with a mental disorder, and while some studies report that Black people report acute occurrences of depression, again are more prone to be impacted by chronic ongoing depression that impairs functioning on a daily basis (Pederson, 2023; Bailey, 2019). Demetrius (2024) also acknowledged recent higher rates of completed suicides among Black men than other gendered groups.

Some studies have explored the prevalence of major depression and anxiety in Black people. One recent study found that it may be more difficult in predicting depression in Black individuals as opposed to their White counterparts when looking at linguistic patterns on using social media with an artificial intelligence program. Researchers note that certain standardized measures may also not be measure depression in various populations including Black men (Gupta, 2024).

In other studies, increased odds of depression symptoms, as well as major depressive disorder and anxiety disorders were shown to be correlated with experiencing high occurrences of discrimination (Volpert -Esmond, et al, 2023). Lee et al (2022) completed a study on anxiety and depression on Black people living in rural black belt areas of Alabama and found that three social determinates of health “defined as health inequities that are shaped by the unequal distribution of available resources, such as money and power, across geographic levels including local, national and global levels” associated with higher depression levels including those who experience higher food insecurity, greater transportation needs, and threats to interpersonal safety (pg. 2649). Chang et al (2018) however examined gender differences and the relationship between loneliness and symptoms of anxiety and depression between black women and men and found that Black women

reported loneliness showed significantly higher levels of depression and anxiety symptoms than Black men. Yet little research has examined on exploring potential gender differences between Black women and Black men in accessing mental health care during the COVID-19 pandemic.

### **Black Mental Health and COVID-19**

COVID-19 has changed everyday life for many people around the world. These changes have impacted mental health and well-being (Volpe et al., 2023). However, the negative impacts of mental health and COVID-19 in Black communities remain poorly understood (Williams et al., 2022; Microni et al., 2021). Some scholars argue that the systems that govern mental health in the United States have lacked the ability to successfully intersect history, beliefs, values, barriers, and access to care when it comes to mental health equity to the detriment of minority communities (Griffith et al., 2019).

Recent research studies have targeted the impact of mental health on different minority populations amid the COVID-19 pandemic. For example, Cui and Han (2022) completed a study on Chinese residents and found that for every 10 percent increase in individuals impacted by COVID-19, participants' mentally unhealthy days increased by 2.19, which is a 46.90% increase compared to the mean value. Chi et al. (2021) conducted a study with university students and revealed that one month after the COVID-19 outbreak, students experienced a 30.8 percent prevalence of post-traumatic stress symptoms. Additionally, Wang et al. (2019) completed a survey in 194 cities in China and found that half of the participants surveyed expressed that the pandemic had either a moderate or severe impact on their mental health.

The frequency of mental health difficulties has also been highlighted among other vulnerable populations (Racine et al., 2022). Eugenio and Climent (2021) conducted gender research focusing on the intersection of COVID-19 and suggested that women, regardless of

ethnicity, experienced some mental distress. White men, however, appeared to experience lower levels of mental distress than Black or other minority men when impacted by COVID-19. Liu and Modir (2020) discussed the disproportionate impact that COVID-19 brought to Black communities, pointing out that Black Americans had a 33 percent higher rate of mortality from COVID-19 than any other ethnic group in the United States, despite only making up 13 percent of the US population.

Gur et al. (2020) expressed the urgent need to examine the mental health repercussions of COVID-19 within marginalized populations and the importance of addressing them early enough. Bauer et al. (2022) similarly noted that COVID-19 elevated the disproportionate risk of loss, trauma, and stress for Black men, yet studies have shown that Black men are the demographic least likely to obtain mental health care. When it comes to Black women, researchers found that 11.1% met the criteria for anxiety and 9.9% met the criteria for depression. It was also noted that Black women were more likely to meet symptoms for depression than White women when applying less conservative screening thresholds. Additional research from Jones et al. (2022) examined the impact of COVID-19 on 46 Black college students and found that many students had a negative reaction to the pandemic, including low mood, elevated stress, social isolation, and greater rates of depression.

### **Mental Health Disparities**

Researchers have suggested that mental health disparities encompass three distinct stages: “disparities between the attention given to mental health and public health, disparities between the health of an individual with mental illness compared with those without, and disparities between populations with respect to mental health and the quality, accessibility, and outcomes of mental health care” (Safran et al., 2009, p. 1962). Soler et al. (2004) highlighted disproportionalities in Black mental health documented in the literature, noting a

bias where Black individuals were more likely to be hospitalized in public facilities and less likely to receive outpatient services compared to White individuals.

Microni et al. (2021) identified specific disparities between populations regarding mental health and the quality, accessibility, and outcomes of mental health care. Their study found that Black respondents reported an increased risk of mental distress and poor mental health outcomes when impacted by COVID-19 compared to other ethnic groups. Similarly, Williams et al. (2022) and Colin et al. (2021) studies highlighted disparities in the health of individuals with mental illness compared to those without. Their research indicated inequities in psychiatric care, including a greater likelihood for Black individuals to experience physical or chemical restraints during mental health evaluations, which can exacerbate mental health distress in this population. Additional disparities in mental health care were revealed by Egan et al. (2022), who discussed contrasts in access, use, and quality of care among different ethnic groups, further illustrating the complex challenges faced by marginalized communities in accessing adequate mental health support.

### **Mental Health Care for Black Americans**

Vinson and Dennis (2021) argue that the history of mental health disparities among Black women and men has deep roots in intersecting inequities that have shaped and influenced health outcomes within the mental health system. Umeh (2019) similarly explores how the development of the mental health system has impacted Black individuals from the antebellum period to the contemporary era. The antebellum period, spanning from 1812 to 1861, was marked by widespread slavery in the southern United States (Liebert, 2023).

Umeh (2019) highlights that during the mid-1800s, prominent American physician John Galt viewed enslaved Black people as immune to mental illness, asserting that they lacked the sophistication to develop such conditions because they were not allowed to engage in activities such as owning property, voting, or holding public office. However, in the 1850s,

another physician named Samuel Cartwright introduced the pseudoscientific concept of “Drapetomania,” which pathologized enslaved Black individuals who attempted to flee their plantations for freedom as suffering from a mental disorder that justified their enslavement and punishment (Opera et al., 2022). This erroneous belief system contributed to the systematic mistreatment and neglect of mental health care for Black people, perpetuating harmful stereotypes and misinformation about their mental capacities and health needs.

Furthermore, these historical misconceptions included ideas that Black people had smaller brains and blood vessels, as well as being biologically related to orangutans, which further entrenched disparities in mental health care for Black communities (Opera et al., 2022). These distorted views and systemic biases have had enduring impacts on how mental health care is provided and perceived within the Black community, influencing access, treatment, and outcomes to this day.

### **Access to Care**

Access to mental health care is currently unavailable to over 100 million people in the United States, as reported by Egan et al, in 2022. Metzger et al. (2023) identified several barriers, such as stigma and provider insensitivity, which hinder access to mental health services. According to Olihe et al. (2022), a needs assessment study revealed disproportionate discrepancies in Black communities’ access to mental health care, particularly in relation to the negative impact of COVID-19. Olihe et al.’s research also highlighted underutilization of mental health services and significant disruptions in social well-being, exacerbating pre-existing mental health inequities. Collins et al (2022) expressed concerns about Black people facing barriers in accessing mental health care, including mistrust, absence of healthcare coverage, lack of transportation, and limited choice of providers. In the following discussion, I will elaborate on select barriers to access as identified in the research study.

## **Disparities in Mental Health Care**

“Disparity” refers to a difference, inequality, or gap between two or more things. In the context of mental health care, disparity specifically refers to differences or inequalities in outcomes, access, treatment, or quality experienced by different groups of people. These differences are typically based on factors such as race, ethnicity, socioeconomic status, gender, age, or geographic location (National Center for Health Statistics, 2022). Health care disparities refer to differences in health outcomes (i.e., higher rates of chronic diseases or lower life expectancy) between racial or ethnic groups (Ndugga; Artiga, 2023).

Healthcare disparities amongst Black individuals in the United States have been well-documented and persist across all layers of healthcare and behavioral healthcare. These disparities stem from a complex interaction of socioeconomic, cultural, and systemic factors that disproportionately affect Black communities. It is important to note that key facets of the health care disparities amongst Black people include access to care, quality of care, health outcomes, maternal and infant health, mental health, and historical and systemic factors (Maness et al, 2021).

Codjoe et al. (2019) highlights several mental health inequalities experienced by people of color, including disparities in communication with mental health providers, less likelihood of being prescribed antidepressant medication, and fewer offered resources for behavioral health services. These disparities contribute to unequal access to and quality of mental health care among minority populations.

Miller et al. (2021) further identify contributing factors that exacerbate barriers to mental health care for people of color. These factors include racial discrimination, stigma associated with mental health issues, mistrust of health care providers, lack of representation of diverse populations in mental health professions, and the use of Afrocentric coping strategies. These barriers collectively contribute to the underutilization of mental health

services and poorer mental health outcomes among racial and ethnic minorities. Thomeer et al (2023) found in their study that Black people reported greater rates of depression and anxiety during the COVID-19 pandemic than their White counterparts, and experience more chronic stages of mental health before obtaining mental health services (Codjoe et al, 2023). Loeb et al (2021) further stipulated how higher levels of anxiety and depression due to COVID-19 for Black women and men may create more mental health risks and wider barriers to overcome. Some studies have also acknowledged some discrepancies of other previous research that reports minorities appear to experience better mental health than White adults regardless of statistics that Black Americans encounter greater levels of stressor exposure that include sociodemographic and psychosocial risks as well as fewer economic resources that may correlate with increased levels of depression features (Robinson et al, 2023). These noted discrepancies have been coined by some scholars as “The mental health paradox” (Thomeer et al, 2023, p. 962). Addressing these disparities requires systemic changes in mental health care delivery, including efforts to reduce stigma, improve cultural competence among providers, increase access to culturally appropriate care, and promote trust and transparency in provider-patient relationships.

### **Cultural Mistrust of the Healthcare System**

A review of relevant research studies and literature confirms that medical mistrust is a significant concern within racial and ethnic communities, particularly among marginalized groups such as the Black community in the United States (Sabetello et al., 2021). According to Jaiswal (2019), there is a correlation between medical mistrust, lower access to, utilization of, and satisfaction with healthcare services, and a reduced tendency to engage in preventive health practices.

Brandow et al. (2022) emphasized the validity of mistrust within the United States mental health service systems by the Black Community, citing the notorious Tuskegee

Syphilis Experiment as a prime example. This unethical study involved purposely withholding treatment from 399 Black men of African ancestry, despite the ready availability of penicillin. Shevelev & Shevelev (2022) highlighted the case of Henrietta Lacks, a Black woman from whom cancer cells were unlawfully taken without her knowledge or consent in the 1950s. These cells have since been used in numerous medical advances, generating substantial profits for the medical field, yet Lacks' family has not received any financial compensation and is currently engaged in a legal battle for the intellectual property rights of their relative.

The exploitation of the Black community in the name of research is further evidenced by the acknowledgment that previous focus groups referred to Black women and men as 'guinea pigs' (Savoia et al., 2024). Some scholars argue that healthcare professionals should address the foundational causes of mistrust and provide historical empathy rather than attempting to change an individual's beliefs (Researchers of Tuft University, 2022).

### **Gaps in the Research and Literature**

The exploration, in the literature and research, of COVID-19's intersectionality with mental health care and gender identification between Black women and men highlighted important gaps in our understanding of race/ethnicity, mental health, and access to holistic healthcare. The research study proposed here aims to expand the intersectional framework of understanding by focusing on within-group differences and how mental health, gender, and events like the COVID-19 pandemic are integrated into intersectionality research. This study proposed to identify the physical and mental health inequities in Black neighborhoods across the United States (Liu & Modir, 2020). Research is needed to determine what current students in counseling programs need to work from a framework of cultural humility and curiosity while addressing these intersections where the disparities are the greatest.

## **Summary and Conclusions**

In Chapter 2, the literature review and examined what is known about the intersectionality of gender identification and mental health concerns, specifically focusing on depression and anxiety among Black women and Black men. The study examined access to mental health services during the COVID-19 pandemic. The chapter provided a detailed review of the current literature, including the search engines used to discover the research and literature. It also included a discussion on the study's theoretical framework, an examination of measured variables and their correlations, and an overall analysis of the primary literature. Chapter 3 provides an overview of the research methodology, including the rationale, research design, data analysis, and potential threats to validity

## Chapter 3: Research Method

### Introduction

Chapter 2 of this study involved conducting a comprehensive literature review. The literature review focused on gathering relevant information about the impact of COVID-19 on mental health, specifically addressing concerns about depression and anxiety.

Intersectionality was used as the theoretical framework within the study to analyze mental health access, disparities, and barriers to treatment between Black women and Black men.

The primary aim of the quantitative study was to investigate gender differences in mental health concerns faced by Black women and Black men during the COVID-19 crisis. Another key objective was to gain insight into how gender and race/ethnicity intersect in relation to accessing mental health care during the COVID-19 crisis. Quantitative research methods were utilized to enhance the understanding of the impact of COVID-19 on mental health, as well as access, disparities, and barriers to treatment for Black women and Black men.

King et al. (2019) emphasized the importance of using quantitative methods for hypothesis testing. Bloomfield and Fisher (2019) highlighted that quantitative research involves describing variables, testing relationships, and examining them using numerical data. They also mentioned that quantitative research is guided by positivist paradigms and specific assumptions, such as establishing a null hypothesis to test the relationship between independent and dependent variables. The acceptance or rejection of the null hypothesis is determined through statistical analyses, leading to conclusions and generalizations that can be applied to the population of interest. For reliable and valid research, it is crucial to ensure internal and external validity, as well as the ability to generalize findings about the study's topic.

## **Research Design and Rationale**

In this quantitative study, I explored how intersecting identities of gender identification and mental health concerns differ between Black women and men when faced with the health crisis of COVID-19. Additionally, I examined the divergence between Black women and men when gender and race/ethnicity intersect in accessing mental health care during COVID-19. Using a quantitative design with an intersectionality lens allowed me to gain a broader understanding of disparities in accessing mental health care for Black women and men.

Intersectionality theory, first introduced by Kimberlé Williams Crenshaw, is the primary framework utilized in this study. This theory focuses on how multiple systems, such as race, health, and gender, overlap with one another (Scarborough et al., 2021). Other scholars have similarly agreed that intersectionality is an appropriate framework for understanding differences within and among groups (Kelly et al., 2022).

A correlational design is also used in this study. Correlational research is a non-experimental approach designed to measure the possible relationship between two or more variables and explore whether there is statistical significance. While this method does not suggest cause-and-effect relationships, it can indicate an association between dependent and independent variables (Scarborough et al., 2021; Seeram, 2019). Bloomfield and Fisher (2019) noted that correlational studies use predictor variables that can be considered negative (where one variable may increase as the other decreases), positive (where both variables simultaneously increase or decrease) or show no correlation (where a change in one variable does not result in a change in another variable).

## **Methodology**

This analysis employed a quantitative design with a descriptive/correlational focus. Prior to conducting the main analyses, all variables were examined for completeness,

distributional characteristics, and suitability for the planned statistical procedures. Categorical demographic variables were reviewed for sparse cell counts and recoded into analytically appropriate groups to satisfy chi square assumptions and improve interpretability. U.S. region was coded into four categories (Southern United States, Other Mainland United States, United States Territories, Outside or Unknown). Education level was organized into four ordered groups (High School or Less, Some College or Technical or Associate degree, Bachelor's degree, Graduate degree). Marital status was coded as Single, Married, Previously Married, or Prefer Not to Say. Employment status was recoded into Employed, Not Employed, or Prefer Not to Say. COVID-19 exposure variables were similarly organized to distinguish household infection, non-household close contact infection, and no known infected contacts.

Subscale scores for all psychological measures (DASS-21, and BMHSS-R, ) were computed according to published scoring protocols. Four BMHSS-R items (Q9, Q14, Q24, Q38) contained one missing value each; given the negligible proportion of missingness and the categorical nature of the items, mode imputation was applied. Internal consistency was assessed using Cronbach's alpha for each subscale, and composite scores (such as intrinsic and extrinsic barriers) were calculated following the recommended scoring structure.

All continuous variables were examined for outliers and univariate distributional anomalies within this study. No observations met criteria for removal. These data preparation procedures were completed prior to inferential analyses to ensure that category frequencies met distributional assumptions, calculated subscales reflected validated measurement models, and variables were appropriate for nonparametric correlations and subsequent analyses.

### **Population, Sampling, and Sampling Procedures**

Overall, this study received 166 responses, however after eliminating sixty-two responses online responses due to incomplete surveys, a sample of 104 respondents were

secured, 36.5% were male (n=38), and 63.5% were women (n= 66). Percentages sum to more than 100% because participants could select more than one racial identity. This study sample comprised of Black women and men from various cities across the United States who lived through the COVID-19 pandemic from March 2020 to March 2023. Specifically, 6.7% were from the Midwest (n=7), 6.7% from the Northwest (n=7), 12.5% from the West, 9.6% from the United States Territory (n= 10), and 1.9% outside of the United States Territory (n=2), while 1.9% preferred not to answer where they lived (n=2). The largest participant response came from the south area of the United States with 60.6% (n= 63).

The research target population were adult Black women and men who were 18 and above and who experienced life during the COVID-19 pandemic. In this study 3.8% of participants were between 18-24 (n=4), 18.3% between 25-34 years old (n=19), 14.4% between the ages of 35- 44 (n=15), 30.8% between the ages of 45-54 (n=32), 16.3% between the ages of 55-64 (n=17), and 16.3% between the ages of 65 and above (n= 17). While African Americans comprised the majority of the survey sample, 95.2 % (n=99), the rest of the sample included 1.0% (n=1) that also identified as Hispanic, 1.9 % (n=2) identified as Indigenous, Aboriginal, or First Nations, and 1.9% (n=2), who preferred not to answer, as participants were given additional multiple choices of racial identifiable ethnicity to choose from. This sample population was requested to have an equivalent education to the fifth grade and access to the Internet or some form of electronic device to retrieve the itemized survey questions to complete.

In this study of 1.0% of participants completed less than high school (n=1), 7.0% completed high school or received GED (n=7), 19% completed some college (n=19), and 5% achieved a technical certification (n=5), while, 6% achieved a associates degree (n=6), 32, achieved a Bachelor's degree (n=32), 27% completed Master's degrees (n=27), 4% earned Doctoral degree (n=4), and 3% completed a professional degree (n=3). Overall, most

individuals in the study were women ( $n = 66$ , 63.5%) and between 35 and 54 years of age ( $n = 47$ , 45.2%). Educational attainment varied, with 30.8% holding a bachelor's degree ( $n = 32$ ) and 32.7% holding a graduate degree ( $n = 34$ ). Participants were primarily single ( $n = 42$ , 40.4%) or married ( $n = 43$ , 41.3%). The majority were employed ( $n = 87$ , 83.7%), resided in the Southern United States ( $n = 63$ , 60.6%), and reported an annual household income of 120,000 USD or more ( $n = 30$ , 28.8%).

(See Table 1).

### **Procedures for Recruitment, Participation, and Data Collection**

Participants for this online study were recruited through online searches and email requests to identify Black leadership organizations for their support and collaboration. These organizations included the National Association of Community Health Centers located across the United States and public health departments in Waco, Texas, and Boston, Massachusetts. Additionally, participants were recruited through email invitations and flyers distributed via the list of services of various Black professional associations, organizations, and churches.

The invitation asked participants to complete an online survey to explore possible gender differences between Black women and Black men confronted with mental health concerns, as well as the differences when gender and race/ethnicity intersect in accessing mental health care during COVID-19. Data were collected using the online survey method and analyzed using SPSS software.

### **Instrumentation and Operationalization of Constructs**

#### ***Demographic Survey***

All participants were asked questions regarding age, gender, education, religion, ethnicity, household income, marital status, employment status, mental health status, COVID-19 history, and mental health history. The demographic survey can be found in Appendix A.

## Measures

### *Depression Anxiety Stress Scale- 21*

To assess psychological distress, participants were asked to rate three negative emotional states: depression, anxiety, and stress symptoms. The Depression Anxiety Stress Scale (DASS-21) contains 21 self-report items (7 items per subscale), including statements such as “I couldn’t seem to experience any positive feelings at all” (depression), “I experienced trembling (e.g., in the hands)” (anxiety), and “I tended to over-react to situations” (stress). Participants indicated the frequency with which they experienced each statement, with ratings ranging from 0 (did not apply to me at all) to 3 (applied to me very much, or most of the time). High scores on the measure suggest a greater frequency of depression, anxiety, and stress symptoms, whereas low scores indicate a lower frequency of these symptoms.

In this sample, the internal reliability coefficients and descriptive statistics were calculated. The reliability tests showed that the reliability coefficients of the items ranged between 0.75 and 0.82. The Cronbach’s Alpha coefficients for the scale dimensions were 0.81 for depression, 0.82 for anxiety, and 0.75 for stress (Lovibond & Lovibond, 1995).

### *COVID-19 Impact Scale (CIS)*

The COVID-19 Impact Scale comprises 10 items designed to measure the psychological effects of COVID-19 among participants. Items are rated on a five-point Likert scale with numerical values ranging from 0 to 4, with higher numbers indicating a greater psychological impact. Example questions from this measure include, “How often are you experiencing irritation regarding COVID-19-related problems currently?” and “How much do the COVID-19-related problems interfere with your interpersonal relationships?” The internal consistency of the COVID-19 Impact Scale is 0.91 (Haewon et al., 2022; Qing et al., 2023).

### ***Barriers to Mental Health Scale (BHHSS-R)***

To better understand the barriers to and access to mental health care between Black women and Black men, participants were asked to measure intrinsic and extrinsic barriers to their mental health. The Barriers to Mental Health Services Scale is a 44-item self-report questionnaire. The items consist of five intrinsic subscales, including help-seeking, stigma, knowledge and fear of psychotherapy, difficulty in finding the right psychotherapist, and beliefs concerning the normalization of depression symptoms. The Cronbach's alpha for the intrinsic subscale is 0.86. Extrinsic subscales include items concerning a psychotherapist's qualifications, insurance concerns, age, transportation problems, and physician referrals. The Cronbach's alpha for the extrinsic subscale is 0.80 (Pepin et al., 2019).

### **Data Analysis Plan**

The statistical analyses that were utilized to test the hypotheses were conducted in a structured sequence to evaluate reliability, descriptive characteristics, group differences, and interrelationships among the psychological variables examined in the study. All analyses were performed using *IBM SPSS Statistics Version 31* and were aligned with the study aims and the distributional characteristics of the data. Internal consistency reliability was first assessed for all subscales of the DASS-21, and BMHSS-R, using Cronbach's alpha. Following verification of reliability, subscale and composite scores were computed according to established scoring procedures for each instrument. Frequency distributions were inspected for categorical variables, and descriptive statistics (means, standard deviations, medians, quartiles, and observed ranges) were calculated for all continuous psychological measures.

Normality was evaluated using the Shapiro–Wilk test, and results indicated that most psychological variables did not meet normality assumptions. Accordingly, nonparametric procedures were applied for analyses involving continuous variables. Group differences across demographic and COVID-19 related variables were examined using chi square tests of

independence, with Fisher's exact test used when expected cell counts fell below recommended thresholds. Effect sizes for categorical comparisons were reported using Cramer's V or phi. Associations among psychological distress, mental health service barriers, and race-related stress were examined using Spearman's rho correlation coefficients. Ninety-five percent confidence intervals were calculated using Fisher's r-to-z transformation to provide robust estimates of association strength.

To evaluate potential gender differences across psychological subscales, a series of multivariate analyses of variance (MANOVA) were conducted for each measurement domain. Separate MANOVAs were performed for the DASS-21 subscales (Depression, Anxiety, Stress), and the BMHSS-R subscales. MANOVA was selected to account for intercorrelations among subscales within each instrument and to control Type I error inflation when testing multivariate group differences. Significant multivariate effects were followed by examination of corresponding univariate tests using appropriate correction procedures. All analyses employed two-tailed significance tests with an alpha level of  $p < .05$ . Effect size estimates were reported alongside  $p$  values to ensure accurate interpretation of the magnitude and precision of observed effects.

### **Reliability Analysis**

Internal consistency estimates for all psychometric instruments used in the study are reported in Table 3. The DASS-21 subscales demonstrated strong reliability, with Cronbach's alpha coefficients of .91 for Depression, .85 for Anxiety, and .89 for Stress, indicating high internal coherence among items. Reliability estimates for the BMHSS-R subscales ranged from low to excellent. Most subscales demonstrated satisfactory reliability, including Stigma (.83), Knowledge and Fear of Psychotherapy (.79), Belief about Inability to Find a Psychotherapist (.83), Belief that Depressive Symptoms are Normal (.75), Insurance or Payment Concerns (.82), Ageism (.80), Concerns about Psychotherapist's Qualifications

(.76), Transportation Concerns (.89), Intrinsic Barriers (.91), and Extrinsic Barriers (.91). The Help Seeking subscale produced a lower coefficient (.57), suggesting reduced internal consistency for that construct in the present sample. Collectively, these coefficients indicate that the majority of the scales used in this study exhibited sound internal reliability for the current population.

### **Threats to Validity**

Quantitative studies must be assessed for internal and external validity (Onwuegbuzie, 2000). Internal validity focuses on detecting differences in the dependent variable specifically influenced by the independent variable. Campbell and Stanley (1963) outlined eight principal categories that can threaten the validity of a study, including history, maturation, testing, instrumentation, statistical regression, biases, experimental mortality, and select maturation interaction.

Challenges in this research study may arise from factors such as the historical context and time frame for data collection, considering that the peak of the COVID-19 pandemic occurred between 2019 and 2022. To address this, participants were asked to specify their experiences during the height of the pandemic and not refer to this time post-pandemic. External validity pertains to the ability to generalize the research findings beyond the targeted demographic to other populations, settings, situations, and times (Onwuegbuzie, 2000). To ensure external validity, this research study sought to gather data randomly from individuals who work for larger counseling centers, community mental health centers, and public health departments. This research study was advertised in as many states as possible. The targeted organizations qualified for the study based on their demographic population.

### **Ethical Procedures**

Ethical considerations addressed to prevent the potential for psychological harm include ensuring participants' confidentiality, informed consent, and privacy, as well as a

strong commitment to deidentifying and protecting all collected data. The Walden University IRB process was utilized to ensure the study design was properly maintained and appropriate actions were taken to minimize risks to participants.

Participants were reminded in all invitations that participation is voluntary. They were informed about the data collection process, the purpose of the study, and their right to withdraw from the survey at any time. Considering the stress and hardship of the pandemic, and the possibility of having family members or friends who may have lost their lives during COVID-19, all participants were provided with contact information for national resources for ongoing emotional support in the invitation flyer if needed.

### **Summary**

Chapter 3 focused on the methodological approach for this quantitative study. This information included providing population sampling and procedures, as well as procedures for recruitment, participation, and data collection. Chapter Three contains information on the instrumentation and operationalization of constructs for this study, which includes a demographic survey, depression anxiety stress scale, COVID-19 impact scale, barriers to mental health scale, and the index of race-related stress scale. This study provides ethical procedures that will guide the appropriate ways to ensure that integrity and ethical standards are utilized throughout this study.

## Chapter 4: Results

### Introduction

The purpose of this quantitative study was to explore gender differences between Black women and Black men confronted with mental health concerns during a health crisis like COVID-19. The study explored understanding the differences in access to mental health care and mental health concerns when gender and race/ethnicity intersect during a crisis. The goal was to enhance the knowledge of counselor educators and mental health professionals, increasing their understanding of perceived barriers and providing advocacy for better mental health care for this population. This chapter explains demographic data descriptively, data analysis, results of the study as well as a summary of findings. In this study I examined the differences between Black women and Black men across the United States of America and surrounding areas of United States Territory.

This quantitative analysis focused on these following research questions for the purpose of exploring gender differences between Black women and Black men confronted with mental health concerns as well as mental health access:

RQ1: Do the intersecting variables of gender identification and mental health concerns (specifically depression and anxiety) differ between Black women and men during the COVID-19 health crisis?

RQ2: Are there differences between how Black women and men accessed mental health care when gender and race/ethnicity intersected during the COVID-19 health crisis?

H1: There are gender differences between Black women and Black men in accessing mental health care during a health crisis like COVID-19. Additionally, there are significant differences in mental health concerns like depression and anxiety.

H0: There are no gender differences between Black women and Black men in accessing mental health care during a health crisis like COVID-19. Additionally, there are no differences in mental health concerns like depression and anxiety.

For this study, an online survey platform was used to collect data, and on average it took participants 17 minutes to complete all survey questions. The time frame for data collection was from September 2024 to December 2024. This study received 166 responses; however, after eliminating 62 responses due to incomplete surveys, a sample of 104 respondents was secured. The first portion included fourteen demographic questions followed by three measures with Likert-based questions approved by the IRB. The COVID-19 impact scale was approved to be used by the IRB but was ultimately eliminated from being used in the results portion of the study due to a technical computer glitch that hid the second page from all participants who completed the survey.

The ages of the participant population ranged from 18 to 65 and over. As mentioned in earlier paragraphs, the participant demographic sample included 36.5% male (n=38), and 63.5% were women (n= 66). While African Americans comprised much of the survey sample, 95.2 % (n=99), the rest of the sample included 1.0% (n=1) who identified as Hispanic, 1.9 % (n=2) who identified as Indigenous, Aboriginal, or First Nations, and 1.9% (n=2) who preferred not to answer. An online survey platform was used to collect data, and on average, it took participants 17 minutes to complete all survey questions.

## **Results**

In this study, the demographic survey analysis showed that 68.3 % (n=71) of the sample experienced COVID-19, and 31.7% (n=33) of the sample who did not experience or were not infected by COVID-19 personally. The descriptive analysis showed that 10.6 (n=11) of the sample had a wife that was impacted by COVID-19, 14.4 % (n=15) had a husband who

was infected with COVID-19, 8.7 % (N=9), experienced a significant partner infected with COVID-19, 9.6% (N=10) of the sample had a child who was impacted by COVID-19, 42.3% (n=44) of the sample experienced a family member infected with COVID-19, 11.5%( n=12) experienced a friend who had been infected by COVID-19, 1.0% (n=1) of the sample reported that that they knew of “ others” who were impacted by COVID -19, and 1.9 % (n=2) of the sample reported that they didn’t know of anyone that was impacted by COVID-19. (See Table 1).

Regarding whether anyone experienced mental health treatment during the COVID-19 pandemic, 13.5% (n=14) of the sample reported “yes,” 83.7% (n=87) reported “no,” meaning mental health treatment during the pandemic was uncommon, and 2.9% preferred not to answer. With respect to feeling as though they would have received better treatment if the sample were a different race or ethnicity during the COVID-19 pandemic, 34.6 % (n=36) reported “yes,” 52.9% reported “no,” and 12.5% (n=13) preferred not to answer. Lastly, with respect to if the sample felt that they would have received better mental health care if they were a different gender during the COVID-19 pandemic, 14.4 % (n=15) reported “yes,” 75.0% r (n=78) reported “no,” and 10.6% (n=11) preferred not to answer. (See Table 1).

Table 1.

## Demographic Descriptive Analysis

	Demographic	Frequency	Percent
Gender	Man	38	36.5
	Woman	66	63
	Total	104	100.0
Ethnic Background	Hispanic	1	1.0
	African American	99	95.2
	Indigenous, Aboriginal, or First Nations	2	1.9
	Prefer not to answer	2	1.9
	Total	104	100.0
United State Regions	Midwest	7	6.7
	Northeast	7	6.7
	South	63	60.6
	West	13	12.5
	United States Territory	10	9.6
	Outside the US or US Territory	2	1.9
	I prefer not to answer	2	1.9
	Total	104	100.0
	Age	18-24 years old	4
25-34 years old		19	18.3
35-44 years old		15	14.4
45-54 years old		32	30.8
55-64 years old		17	16.3
65+ years old		17	16.3
Total		104	100.0
Education	Less than High School	1	1.0
	High School Diploma / GED)	7	6.7
	Some college (no degree)	19	18.3
	Technical certification	5	4.8
	Associate degree (2-year)	6	5.8
	Bachelor's degree (4-year)	32	30.8
	Master's degree	27	26.0
	Doctoral degree	4	3.8
	Professional degree (JD, MD)	3	2.9
	Total	104	100.0
Household Income	\$0-\$29,999	5	4.8
	\$30,000-\$59,999	22	21.2
	\$60,000-\$89,999	23	22.1
	\$90,000-\$119,999	12	11.5
	\$120,000+	30	28.8
	Prefer not to say	12	11.5
Total	104	100.0	
Marital Status	Married	43	41.3
	Widowed	5	4.8
	Divorced	12	11.5
	Separated	1	1.0
	Single	42	40.4
	Prefer not to say	1	1.0
	Total	104	100.0

(table continues)

Table 1 cont.

Demographic Descriptive Analysis

Demographic	Frequency	Percent	Demographic
Personal COVID-19 Infection/Experience	Yes.	71	68.3
	No	33	31.7
	Total	104	100.0
COVID-19 Infection in Family in Family / Contacts	Wife	11	10.6
	Husband	15	14.4
	Significant other (Partner)	9	8.7
	Child	10	9.6
	Family member	44	42.3
	Friend	12	11.5
	Other	1	1.0
	No-one That I know	2	1.9
	Total	104	100.0
Other Known Who Has Experienced COVID-19	Wife	11	10.6
	Husband	15	14.4
	Significant other (Partner)	9	8.7
	Child	10	9.6
	Family member	44	42.3
	Friend	12	11.5
	Other	1	1.0
	No-one That I know	2	1.9
	Total	104	100.0
Mental Health Treatment During COVID-19 Pandemic	Yes	14	13.5
	No	87	83.7
	Prefer not to answer	3	2.9
	Total	104	100.0
Perceived Mental Health Treatment if a Different Race or Ethnicity During COVID-19 Pandemic	Yes	36	34.6
	No	55	52.9
	Prefer not to answer	13	12.5
Total	104	100.0	
Perceived Feelings of Better Mental Health Care if You Were a Different Gender During the COVID-19 Pandemic	Yes	15	14.4
	No	78	75.0
	Prefer not to answer	11	10.6
	Total	104	100.0

Note. N = 104. Counts (n) and percentages (%) are based on the total sample

### ***Gender Differences in Demographic and COVID-19 Characteristics***

A series of chi square tests of independence (and Fisher's exact tests when assumptions were not met) examined whether demographic and COVID-19 related characteristics differed by gender. Gender was not significantly associated with age group,  $\chi^2(2, N = 104) = 4.56, p = .102$ , Cramer's  $V = .21$ ; ethnic background,  $\chi^2(3, N = 104) = 1.47, p = .690$ , Cramer's  $V = .12$ ; U.S. region of residence,  $\chi^2(3, N = 104) = 0.28, p = .963$ , Cramer's  $V = .05$ ; education level,  $\chi^2(3, N = 104) = 1.47, p = .690$ , Cramer's  $V = .12$ ; marital status,  $\chi^2(2, N = 103) = 3.85, p = .146$ , Cramer's  $V = .19$ ; employment status, Fisher's exact  $p = 1.00, \phi = .03$ ; annual household income,  $\chi^2(5, N = 104) = 8.76, p = .119$ , Cramer's  $V = .29$ ; personal COVID-19 infection,  $\chi^2(1, N = 104) = 2.98, p = .085, \phi = .17$ ; mental health

treatment during COVID-19,  $\chi^2(2, N = 104) = 2.63, p = .269$ , Cramer's  $V = .16$ ; perceived racial treatment disparity,  $\chi^2(2, N = 104) = 0.69, p = .709$ , Cramer's  $V = .08$ ; and perceived gender treatment disparity,  $\chi^2(2, N = 104) = 1.02, p = .600$ , Cramer's  $V = .10$ . The only significant association occurred for COVID-19 infection in close contacts,  $\chi^2(2, N = 104) = 6.46, p = .040$ , Cramer's  $V = .25$ , with women more likely to report a household member infection (93.9% vs. 78.9%). Overall, these findings suggest that gender was not meaningfully associated with any demographic or psychosocial variable examined, with the exception that women were more likely to report COVID-19 infection among close contacts.

Table 2.

*Chi Square and Fisher's Exact Tests Examining Associations Between Gender and Demographic, Socioeconomic, and COVID-19 Related Characteristics in a Sample of Black/African American Adults* Table 21

*Chi Square and Fisher's Exact Tests Examining Associations Between Gender and Demographic, Socioeconomic, and COVID-19 Related Characteristics in a Sample of Black/African American Adults*

Study Variables		Gender		n	%	p
		Man	Woman			
Age	18-34	10	26.3	13	19.7	.102
	35-54	12	31.6	35	53.0	
	55+	16	42.1	18	27.3	
Ethnic Background	African American	36	94.7	62	93.9	.690
	Hispanic or Latino	1	2.6	1	1.5	
	First Nations	0	0.0	2	3.0	
	Prefer not to answer	1	2.6	1	1.5	
U.S. Region	Southern U.S.	23	60.5	40	60.6	.963
	Other Mainland U.S.	10	26.3	17	25.8	
	U.S. Territories	4	10.5	6	9.1	

Education Level	Outside/Unknown	1	2.6	3	4.5	.690
	High school or less	3	7.9	5	7.6	
	Some college+	11	28.9	19	28.8	
	Bachelor's degree	14	36.8	18	27.3	
Marital Status	Graduate degree	10	26.3	24	36.4	.146
	Single	17	44.7	25	38.5	
	Married	18	47.4	25	38.5	
Employment Status	Previously married	3	7.9	15	23.1	1.00*
	Employed	31	88.6	56	86.2	
	Not employed	4	11.4	9	13.8	
Annual Household Income	\$0-\$29,999	4	10.5	1	1.5	.119
	\$30,000-\$59,999	4	10.5	18	27.3	
	\$60,000-\$89,999	9	23.7	14	21.2	
	\$90,000-\$119,999	3	7.9	9	13.6	
	\$120,000+	13	34.2	17	25.8	
	Prefer not to say	5	13.2	7	10.6	
Personal COVID-19 Infection	No	16	42.1	17	25.8	.085
	Yes	22	57.9	49	74.2	
COVID-19 Infection in Contacts	Household member infected	30	78.9	62	93.9	.040
	Non-household close contact infected	6	15.8	4	6.1	
	No known infected contacts	2	5.3	0	0.0	
Mental Health Treatment During COVID-19	No	33	86.8	54	81.8	.269
	Yes	3	7.9	11	16.7	
Perceived Racial Treatment Disparity	Prefer not to answer	2	5.3	1	1.5	.709
	No	19	50.0	36	54.5	
Perceived Gender Treatment Disparity	Yes	15	39.5	21	31.8	.600
	Prefer not to answer	4	10.5	9	13.6	
Perceived Gender Treatment Disparity	No	29	76.3	49	74.2	.600
	Yes	4	10.5	11	16.7	
	Prefer not to answer	5	13.2	6	9.1	

Note. p values reflect two-sided tests for chi square test or fisher test statistic. Fisher's exact test was reported where expected cell counts were below 5. Percentages represent column percentages within gender groups. All analyses were based on complete cases for each comparison.

## **Dass 21 Data Descriptive Analysis**

In this section, the DASS-21 scale was analyzed to address the following research question:

RQ1: Do the intersecting variables of gender identification and mental health concerns (specifically depression and anxiety) differ between Black women and men during the COVID-19 health crisis?

The DASS-21 scale was based on the average scores reported for both men and women. These sections had scores ranging from 0 to 3, where 0 represented not applicable and 3 meant very much so. Scores for each scale were calculated by adding up scores. Raw scores were then multiplied by two. The mean and standard deviation were also obtained from the subscales. The measures also indicated that higher scores relate to greater severity of depression, anxiety, stress, and depression symptoms. The mean DASS-21 depression score was 7.3 (SD=7.0) for Black men and 9.03 (SD=10.23) for Black Women, with a range of 0-21. The mean DASS-21 Anxiety score was 9.4 (SD=9.2) for Black Men, and 10 (SD=10.8) for Black women, with a range of 0-21. The mean DASS-21 Stress score for Black men was 13.2 (SD=9.9), and 14.1 (SD=11.9), with a range for 0-21.

The analysis showed that 67% of the overall depression sample scored within normal range (0–9), 7% of the overall sample scored within mild range (10–12), while 13 % of the overall sample scored within moderate range (13–20) and 6% of the overall sample scored within severe range (21–27), and 6% of the sample scored extremely severe depression symptoms (28–42).

The analysis also showed that 52% of the overall anxiety sample scored within the normal range (0–6), 9% of the overall sample scored within the mild range (7–9), while 14% of the overall sample scored within the moderate range (10–14). The overall sample severe anxiety score was 9% (15–19), while extremely severe depression symptoms were 16% (20–

42). The analysis showed that 45% of the overall stress sample scored within normal range (0–10), 17% of the overall sample scored within mild range (11–18), while 9% of the overall sample scored within moderate range (19–26) of the overall sample scored. In addition, the overall severe anxiety score was 9% (27–34), while the extremely severe depression score was 4%. (35–42).

Gender differences were found in the depression subscale between Black men and Black women; however, no statistical significance was detected. The descriptive analysis showed that 71% of Black men and 65% Black women scored within the normal depression ranges (0–9), 5% of Black men and 9% of Black women scored within the mild range (10–12), 18% of Black men and 11% of Black woman scored within the moderate range (13–20), 3% of Black Men and 8% Black woman scored within severe range (21–27, and 3% of Black Men and 8% Black woman scored within extremely severe range (28–42). Gender differences were found in anxiety between Black men and Black women.

The descriptive analysis showed that 47% of Black men and 55% Black women scored within the normal anxiety ranges (0–6), 13% of Black men and 6% of Black women scored within the mild range (7–9), 16% of Black men and 14% of Black woman scored within the moderate range (10–14), 8% of Black Men and 9% Black woman scored within severe range (18–19), and 16% of Black Men and 17% Black woman scored within extremely severe range (20–42); however no statistical significance was detected. Gender differences were found in stress scores between Black men and Black women; however, no statistical significance was detected. The descriptive analysis showed that 39% of Black men and 45% Black women scored within the normal stress ranges (0–10), 5% of Black men and 30% of Black women scored within the mild range (11–18), 18% of Black men and 8% of Black woman scored within the moderate range (19–26), 3% of Black Men and 8% Black woman scored within severe range (27–34), and 3% of Black Men and 9% Black woman

scored within extremely severe range (35–42). Question items on the DASS 21 for Depression were as follows: (See Figure 1) and (Table 2)

- Question:3: I couldn't seem to experience any positive feeling at all
- Question 5: I found it difficult to work up the initiative to do things.
- Question 10: I felt that I had nothing to look forward to.
- Question 13: I felt downhearted and blue.
- Question 16: I was unable to become enthusiastic about anything.
- Question 17: I felt I wasn't worth much as a person.
- Question 21: I felt that life was meaningless

Question items on the DASS 21 for Anxiety are as follows:

- Question 2: I was aware of the dryness of my mouth.
- Question: 4: I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)
- Question. 7: I experienced trembling (e.g. in the hands)
- Question: 9: I was worried about situations in which I might panic and make a fool of myself
- Question 15: I felt I was close to panic.
- Question: 19: I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)
- Question 20: I felt scared without any good reason.

Question items on the DASS 21 for Stress are as follows:

- Question 1: I found it hard to wind down.
- Question 6: I tended to overreact to situations.
- Question 8: I felt that I was using a lot of nervous energy
- Question 11: I found myself getting agitated.

- Question 12: I found it difficult to relax
- Question 14: I was intolerant of anything that kept me from getting on with what I was doing.
- Question 18: I felt that I was rather touch.

Figure 1

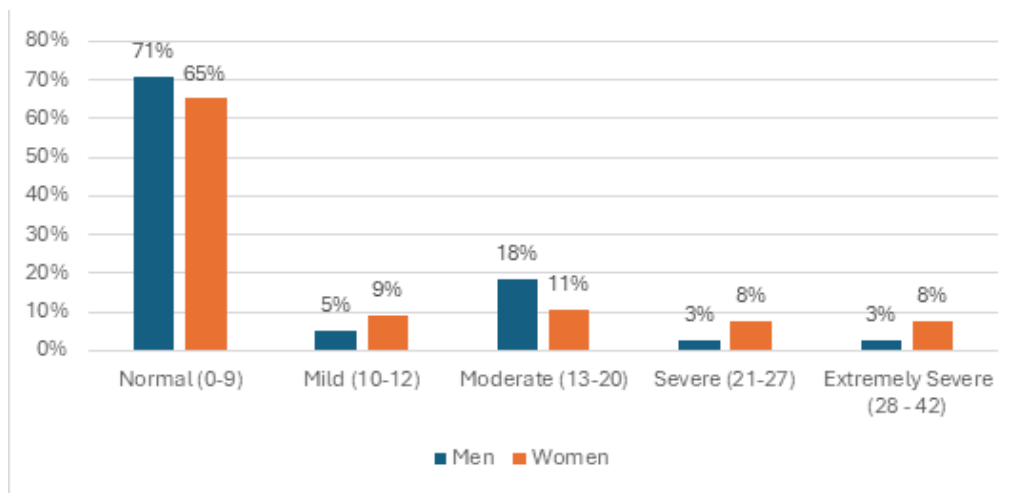
*DASS 21 – Descriptive Graphic*

Figure 2

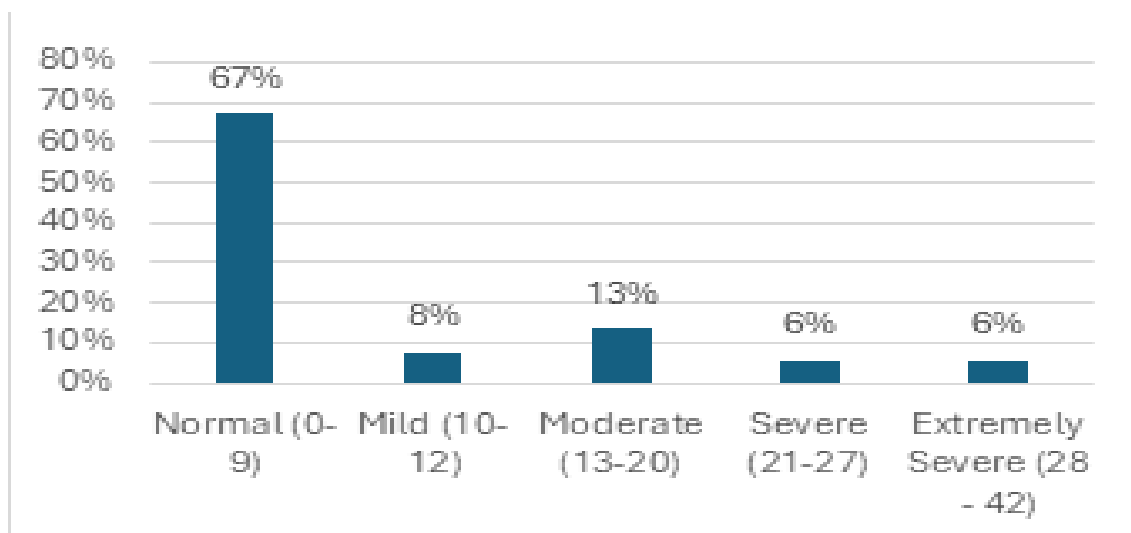
*Depression (Overall Sample)*

Figure 3

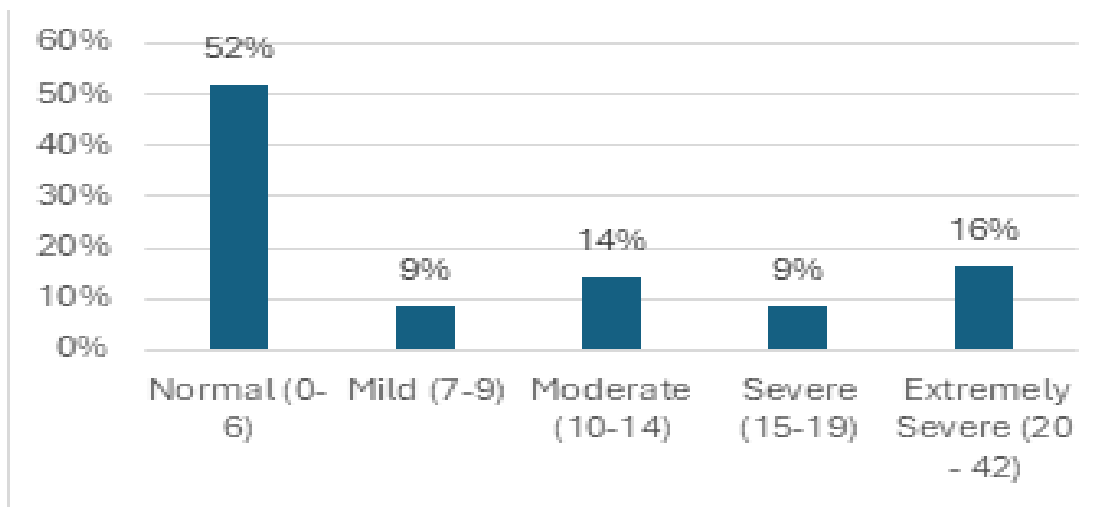
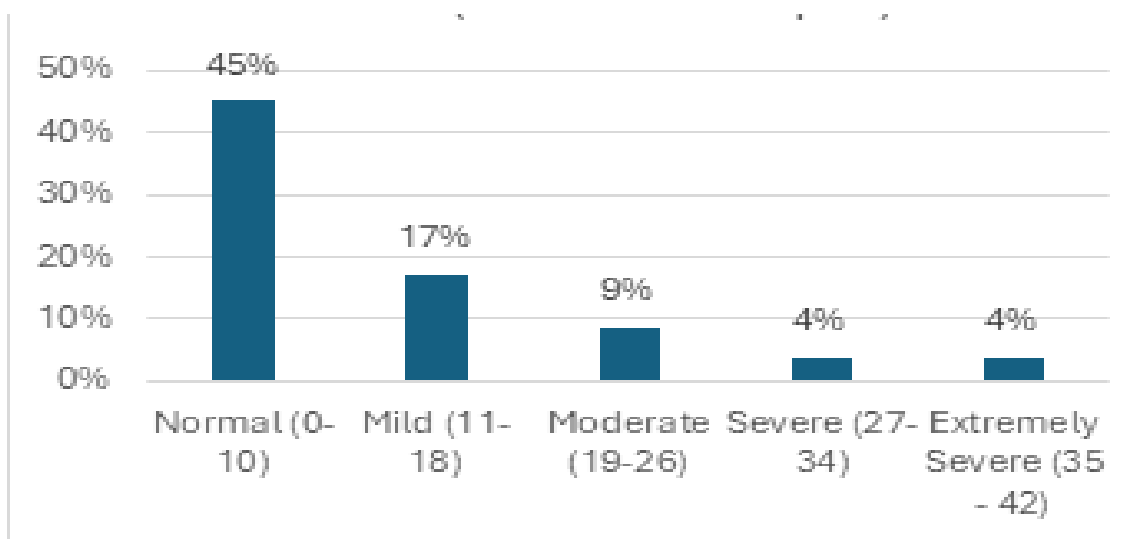
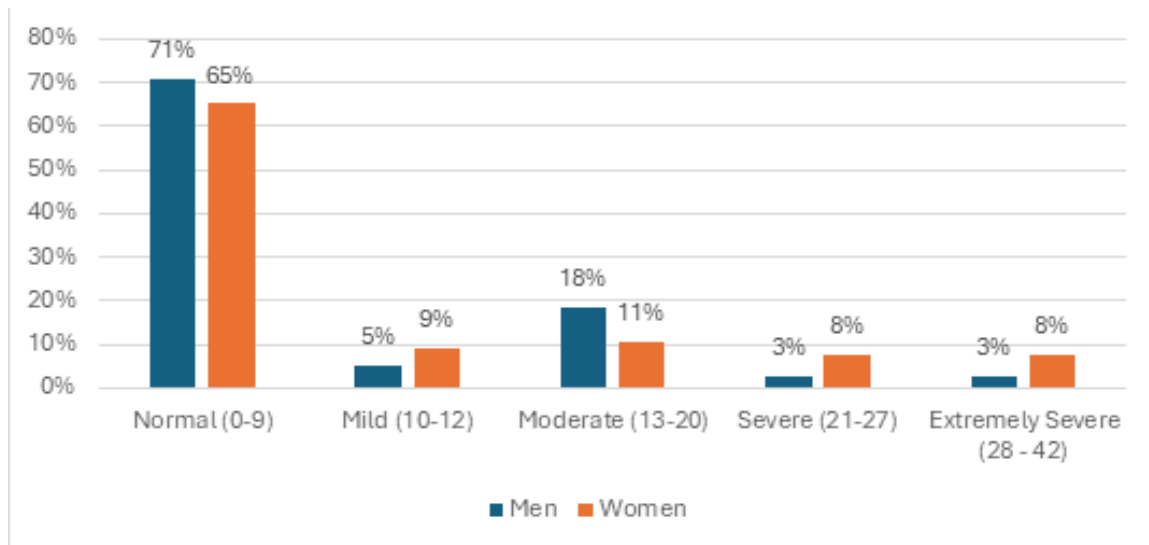
*Anxiety (Overall Sample)*

Figure 4

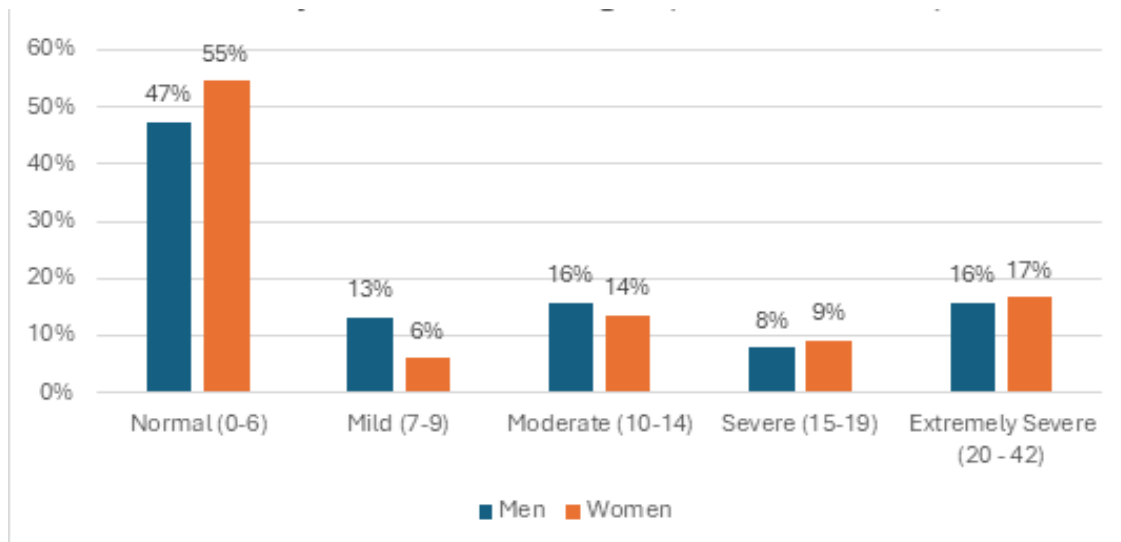
*Stress Overall Sample*

**Figure 5**

Depression Score Percentages (Men vs. Women)

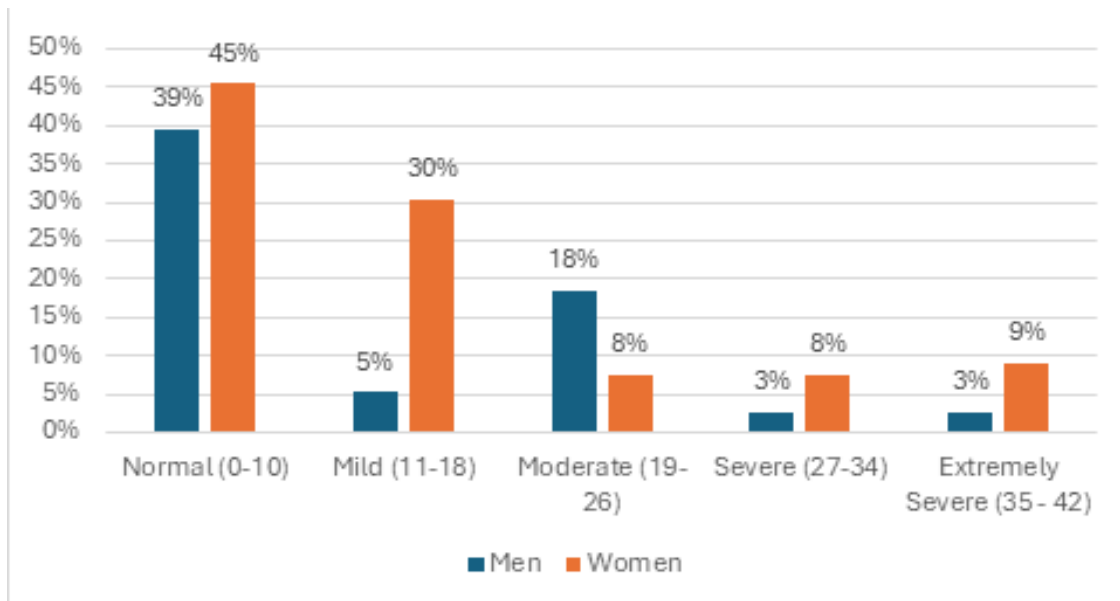
**Figure 6**

Anxiety Score Percentages (Black Men vs. Black Women)

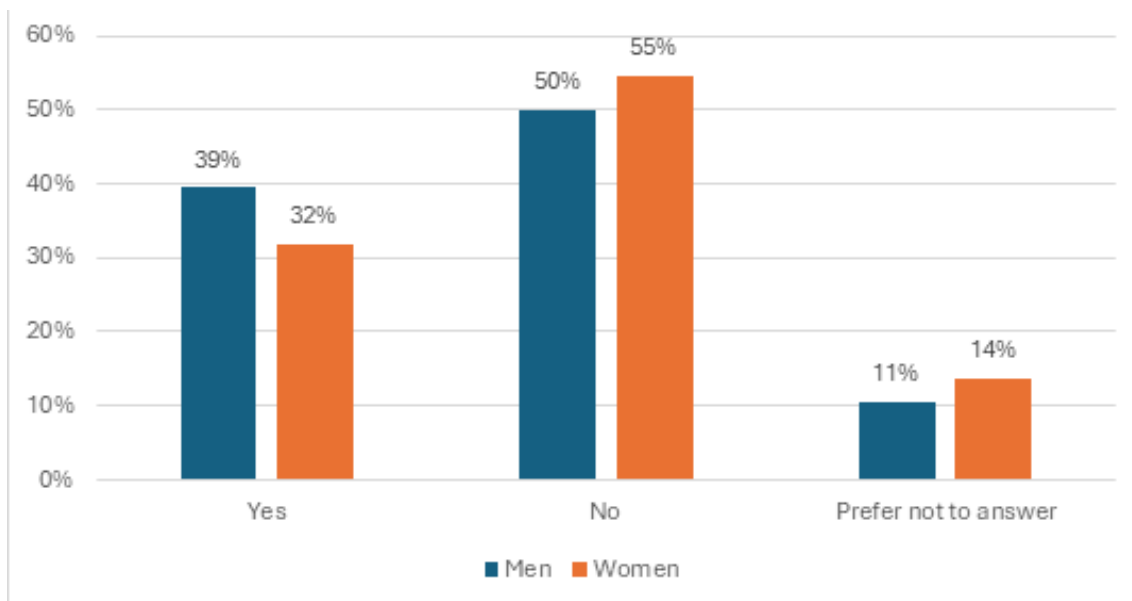


**Figure 7**

Stress Score Percentages (Black Men vs. Black Women)

**Figure 8**

Positive Attitudes Toward Receiving Mental Health Care if Different Race or Ethnicity  
Between Black Men and Women



**H1:** There are gender differences between Black women and Black men in accessing mental health care during a health crisis like COVID-19. Additionally, there are significant differences in mental health concerns like depression and anxiety.

### MANOVA Analysis DASS-21 Results

#### *Gender Differences in Depression Anxiety Stress Scales (DASS-21)*

A MANOVA multivariate test was also conducted on Depression, Anxiety, and Stress subscales. The three subscales were analyzed as dependent variables against the independent variable gender. MANOVA assumptions were however evaluated prior to conducting the analysis. Equality of covariance matrices was supported by a nonsignificant Box's M test,  $M = 12.21, p = .067$ , indicating that the covariance structures across gender groups were comparable. Levene's tests demonstrated that the assumption of homogeneity of variances was satisfied for Anxiety ( $p = .439$ ) and Stress ( $p = .336$ ), with only a mild deviation observed for Depression ( $p = .029$ ); however, given the robustness of MANOVA to minor violations of variance homogeneity in moderately sized samples, this deviation was not considered consequential. The dependent variables were strongly intercorrelated ( $r_s = .82$  to  $.84$ ), aligning with the theoretical structure of the DASS-21 and supporting the use of a multivariate model. Visual inspection of residual plots did not reveal meaningful departures from linearity or normality. Collectively, the assumption checks indicated that the data were suitable for MANOVA.

A one-way MANOVA was conducted to examine whether emotional distress including depression, anxiety and stress symptoms differed by gender. The multivariate effect of gender was not statistically significant, Wilks'  $\Lambda = .984, F(3, 100) = 0.533, p = .661$ , partial  $\eta^2 = .016$ , indicating no overall group differences across the combined outcomes of depression, anxiety, and stress. Follow-up univariate analyses were consistent with the multivariate findings. For depression, men ( $M = 7.26, SD = 7.03$ ) reported slightly lower

scores than women ( $M = 9.03$ ,  $SD = 10.23$ ), although the difference was not statistically significant,  $F(1, 102) = 0.89$ ,  $p = .348$ , partial  $\eta^2 = .009$ . Anxiety scores were similarly comparable between men ( $M = 9.37$ ,  $SD = 9.21$ ) and women ( $M = 10.00$ ,  $SD = 10.79$ ),  $F(1, 102) = 0.09$ ,  $p = .763$ , partial  $\eta^2 = .001$ . Stress levels were likewise similar for men ( $M = 13.16$ ,  $SD = 9.89$ ) and women ( $M = 14.09$ ,  $SD = 11.93$ ),  $F(1, 102) = 0.17$ ,  $p = .684$ , partial  $\eta^2 = .002$ . Overall, these results indicate that men and women in this sample experienced comparable levels of emotional distress across all three DASS-21 domains.

Table 4.

*Descriptive Statistics for Depression, Anxiety, and Stress by Gender*

Table 4 Descriptive Statistics

Table 3 Descriptive Statistics for Depression Anxiety Stress by Gender

Subscale	Men (n = 38)	Women (n = 66)	Total (N = 104)
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>
Depression	7.26 (7.03)	9.03 (10.23)	8.38 (9.19)
Anxiety	9.37 (9.21)	10.00 (10.79)	9.77 (10.20)
Stress	13.16 (9.89)	14.09 (11.93)	13.75 (11.19)

*Note.* Values represent mean ( $M$ ) scores with standard deviations ( $SD$ ) in parentheses. Higher values reflect greater symptom severity on each DASS-21 subscale.

Table 5.

*Multivariate and Univariate Test Results for Gender Differences in Emotional Distress*

Table 5 Multivariate and Univariate Test 1

Table 4 Multivariate and Univariate Test Results for gender Differences in Emotional

Distress

Outcome	<i>Wilks' <math>\Lambda</math></i>	<i>F</i>	<i>df (df1, df2)</i>	<i>p</i>	<i>Partial <math>\eta^2</math></i>
Multivariate test (combined DV)	0.984	0.533	3, 100	0.661	0.016
Depression	-	0.89	1, 102	0.348	0.009
Anxiety	-	0.092	1, 102	0.763	0.001
Stress	-	0.166	1, 102	0.684	0.002

*Note.* The multivariate test reports Wilks' Lambda. Univariate tests represent follow-up ANOVAs for each dependent variable. Partial  $\eta^2$  represents effect size.

### **Mental Health Services Revised (BHMSS-R) Descriptive Findings**

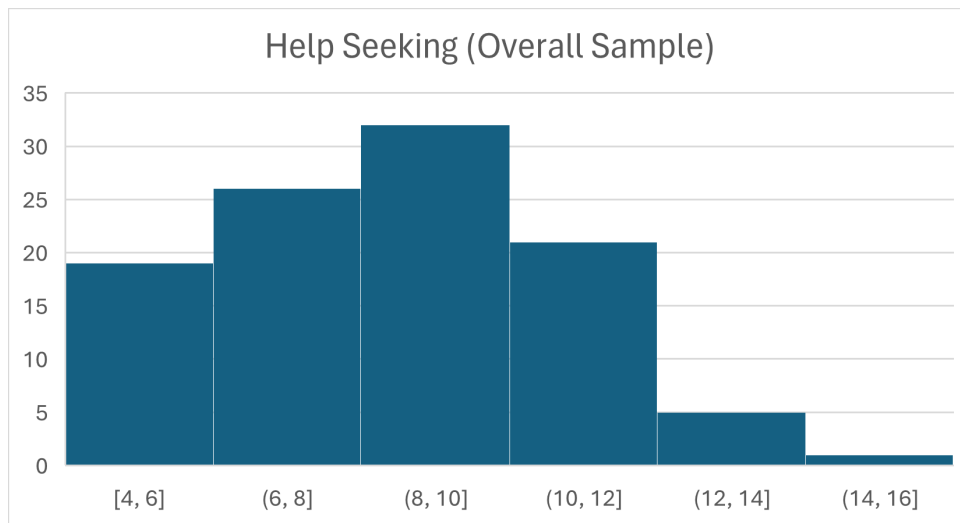
This assessment was utilized to investigate access to mental health care services and treatment among Black women and Black men during COVID-19. The research question was as follows:

RQ1: Are there differences between how Black women and men accessed mental health care when gender and race/ethnicity intersected during the COVID-19 health crisis?

All the charts for Appendix B are based on the proportions of respondents who recorded a score of 3 and 4, meaning that they agreed and strongly agreed, respectively, to the questions answered. Each side-by-side bar compares the total percentage of agree and strongly agreed responses between men and women to the same question. The help-seeking subscale histogram below mostly shows a standard distribution with a slight skew to the right. The tables below show descriptive statistics for the whole data set comprising range (maximum – minimum), mean, and standard deviation for the ten subscales of BMHSS-R, including intrinsic and extrinsic barriers.

*Figure 9 Help Seeking (Overall Sample)*

Figure 9 Help Seeking (Overall Sample)



Help Seeking (Overall Sample) 1

**Table 6***Barriers of Mental Health Services Revised (BHMSS-R) Descriptive Findings*

Table 6 Barriers of Mental Health 1

Table 5 Barriers of Mental Health Services Revised (BHMSS-R) Descriptive Findings

Measurement	N	Minimum	Maximum	Mean	Std. Deviation
Help Seeking	104	4	15	8.86	<b>2.36</b>
Stigma	104	5	20	8.59	<b>3.15</b>
Knowledge and Fear of Psychotherapy	104	5	20	9.85	3.27
Belief about Inability to Find a Psychotherapist	104	5	20	9.85	3.27
Belief that Depressive Symptoms are Normal	104	5	20	10.23	3.40
Insurance/Payment Concerns	104	3	12	6.88	2.40
Ageism	104	5	17	7.82	2.55
Concerns about Psychotherapist's Qualifications	104	4	19	9.07	2.94
Physician Referral	104	3	11	5.72	1.99
Transportation Concerns	104	5	20	8.23	3.42
Intrinsic Barriers	104	23	87	47.37	11.81
Extrinsic Barriers	104	21	71	37.58	10.22
Transportation Concerns	104	5	20	8.23	3.42

**Intercorrelations for Barriers of Mental Health Services Revised (BHMSS-R)**

The correlation tables below were conducted, and the men's and women's BHMSS-R scores are shown. The highlighted cell shows median to strong correlation coefficients for

subscales that were more strongly correlated. The strength of intercorrelations in Black men is as follows: *moderate*, 0.4–0.59; *strong* 0.6–0.79; *very strong*, 0.8–1.00. Findings show that ageism was moderately correlated with help seeking ( $r = 0.56$ ), physician referral is moderately correlated with knowledge and fear of psychotherapy ( $r = 0.58$ ), agism was strongly correlated with stigma ( $r = 0.65$ .) Belief that depressive symptoms are normal was strongly correlated with knowledge and fear of psychotherapy ( $r = 0.65$ ), concerns about psychotherapists qualifications and knowledge and fear of psychotherapy ( $r = 0.77$ ).

Belief that depressive symptoms are normal was strongly correlated belief about inability to find a psychotherapist ( $r = 0.65$ ), ageism was moderately correlated with belief about inability to find a psychotherapist ( $r = 0.56$ ), concerns about psychotherapists qualifications was strongly correlated with belief about inability to find a psychotherapist ( $r = 0.77$ ); physician referral was moderately correlated belief about inability to find a psychotherapist ( $r = 0.58$ ), insurance /payments concerns was moderately correlated with belief that depressive symptoms are normal ( $r = 0.55$ ), ageism is strongly correlated with belief that depressive symptoms are normal ( $r = 0.60$ ), physician referral was strongly correlated with belief that depressive symptoms are normal ( $r = 0.77$ ), concerns about psychotherapist's qualification was strongly correlated with agism ( $r = 0.62$ ), physician referral was strongly correlated with agism ( $r = 0.70$ ), and physician referral was strongly correlated concerns about psychotherapists qualifications in Black men ( $r = 0.64$ ).

Figure 10

## Intercorrelation Scores for Barriers of Mental Health Services Revised (BHMSS-R)

Figure 10 Intercorrelation Scores for Barriers of Mental Health Services Revised (BHMSS-R)

	Help Seeking	Stigma	Knowledge and Fear of Psychotherapy	Belief about Inability to Find a Psychotherapist	Belief that Depressive Symptoms are Normal	Insurance/Payment Concerns	Ageism	Concerns about Psychotherapist's Qualifications	Physician Referral	Transportation Concerns
Help Seeking	1									
Stigma	0.47	1.00								
Knowledge and Fear of Psychotherapy	0.48	0.49	1.00							
Belief about Inability to Find a Psychotherapist	0.48	0.49	1.00	1.00						
Belief that Depressive Symptoms are Normal	0.46	0.52	0.65	0.65	1.00					
Insurance/Payment Concerns	0.43	0.01	0.25	0.25	0.55	1.00				
Ageism	0.56	0.65	0.56	0.56	0.60	0.27	1.00			
Concerns about Psychotherapist's Qualifications	0.43	0.58	0.77	0.77	0.50	0.12	0.62	1.00		
Physician Referral	0.48	0.52	0.58	0.58	0.77	0.38	0.70	0.64	1.00	
Transportation Concerns	0.08	0.15	0.38	0.38	0.47	0.31	0.39	0.30	0.53	1

Note. moderate, 0.4–0.59; strong 0.6–0.79; very strong, 0.8–1.00

The below correlation table is for women's BMHSS-R scores, the highlighted cell shows median to strong correlation coefficients for subscales that were more and strongly correlated. The strength of correlations found in Black women were as follows: Knowledge and fear of psychotherapy was strongly correlated with help seeking ( $r=0.65$ ), belief about inability to find a psychotherapist was strongly correlated with help seeking ( $r=0.65$ ), belief that depressive symptoms are normal was moderately correlated with help seeking ( $r=0.57$ ), Knowledge and fear of psychotherapy was moderately correlated with stigma ( $r=0.58$ ), belief about inability to find a psychotherapist was moderately correlated with stigma ( $r=0.58$ ), belief that depressive symptoms are normal was strongly correlated with stigma ( $r=0.72$ ), ageism was strongly correlated with stigma ( $r=0.69$ ), concerns about psychotherapists qualifications was strongly correlated with stigma ( $r=0.73$ ), belief that depressive symptoms are normal was strongly correlated with belief about inability to find a psychotherapist

( $r=0.79$ ), belief that depressive symptoms are normal was strongly correlated with knowledge and fear of psychotherapy( $r=0.79$ ).

With regards to other correlation coefficients with Black women, the cells show that Insurance/ payments was moderately correlated with knowledge and fear of psychotherapy ( $r=0.56$ ), ageism was strongly correlated with knowledge and fear of psychotherapy ( $r=0.71$ ), concerns about psychotherapists qualifications was strongly correlated with knowledge and fear of psychotherapy ( $r=0.77$ ), physician referral was strongly correlated with knowledge and fear of psychotherapy ( $r=0.66$ ), Insurance/ payments was moderately correlated with belief about inability to find a psychotherapist ( $r=0.56$ ), ageism was strongly correlated with belief about inability to find a psychotherapist ( $r=0.71$ ), concerns about psychotherapists qualifications was strongly correlated with belief about inability to find a psychotherapist ( $r=0.77$ ), physician referral was strongly correlated with belief about inability to find a psychotherapist ( $r=0.66$ ), ageism was strongly correlated with belief that depressive symptoms are normal ( $r=0.64$ ), concerns about psychotherapists qualifications was strongly correlated with belief that depressive symptoms are normal ( $r=0.75$ ), physician referral was strongly correlated with belief that depressive symptoms are normal ( $r=0.60$ ), concerns about psychotherapists qualifications was moderately correlated with insurance/payment concerns ( $r=0.59$ ), concerns about psychotherapists qualifications was strongly correlated agism ( $r=0.78$ ), and physician referral was moderately correlated with concerns about psychotherapists qualifications ( $r=0.58$ ) for Black women.

## Correlations for Barriers of Mental Health Services Revised (BHMSS-R) Black Women

Figure 11 Correlations for Barriers of Mental Health Services Revised (BHMSS-R) Black Women

	Help Seeking	Stigma	Knowledge and Fear of Psychotherapy	Belief about Inability to Find a Psychotherapist	Belief that Depressive Symptoms are Normal	Insurance/Payment Concerns	Ageism	Concerns about Psychotherapist's Qualifications	Physician Referral	Transportation Concerns
Help Seeking	1.00									
Stigma	0.49	1.00								
Knowledge and Fear of Psychotherapy	0.65	0.58	1.00							
Belief about Inability to Find a Psychotherapist	0.65	0.58	1.00	1.00						
Belief that Depressive Symptoms are Normal	0.57	0.72	0.79	0.79	1.00					
Insurance/Payment Concerns	0.42	0.46	0.56	0.56	0.52	1.00				
Ageism	0.47	0.69	0.71	0.71	0.64	0.49	1.00			
Concerns about Psychotherapist's Qualifications	0.50	0.73	0.77	0.77	0.75	0.59	0.78	1.00		
Physician Referral	0.43	0.51	0.66	0.66	0.60	0.45	0.48	0.58	1.00	
Transportation Concerns	0.37	0.50	0.48	0.48	0.54	0.53	0.53	0.49	0.41	1.00

Note. moderate, 0.4–0.59; strong 0.6–0.79; very strong, 0.8–1.00

## Cronbach's Alpha and BMHSS-R Score Differences on Averages on Scores for Men and Women

The tables below show Cronbach's alpha that was conducted on the ten BMHSS-R subscales alongside mean and standard deviation for each subscale. The Cronbach's of 0.7 and higher indicates stronger internal consistency of measures. This output illustrates that all but help-seeking had acceptable (0.7), good (0.8) and excellent ( $\geq 0.9$ ) inter-consistency scores. An independent t-tests with an assumption of unequal variance were performed to examine the differences in average scores for BMHSS-R for men and women. The unequal variance assumption was used because of a large sample size differences between men and women. A null hypothesis assumes no difference in mean, and an alternative is a difference in mean. Subscales with highlighted p-values showcased those that had notable differences in means. An alpha level of .05 was used for this statistical test. Notable differences were

illustrated between Black men and women with the subscale of stigma (M=9.53, SD=3.01) women (M=8.05, SD= 3.12)  $t(79) = 2.4, p=0.01$ .

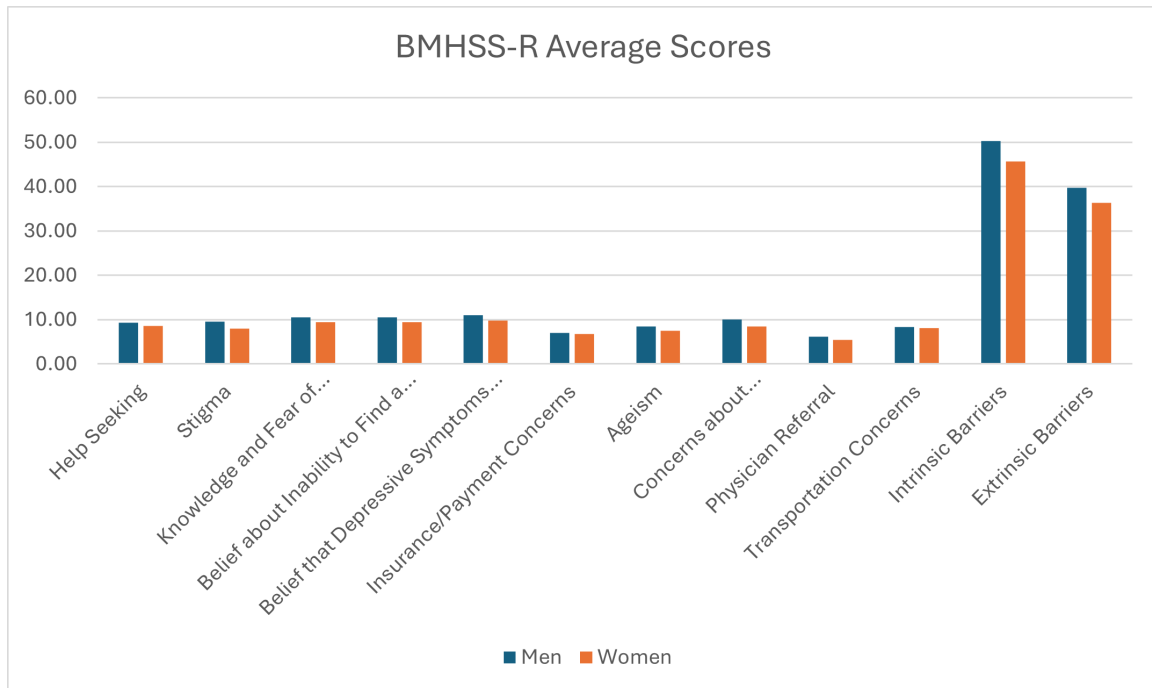
Differences were detected between Black men and women with the subscale of the belief that depressive symptoms are normal, (M=8.45, SD=2.52) and women (M=7.45, SD=2.52)  $t(77) = 1.93, p=0.03$ . Other differences were detected between Black men and women with ageism subscale, (M=8.45, SD=2.52) women (M=7.45, SD=2.52)  $t(77) = 1.93, p=0.03$ .; between Black men and women with the concerns about psychotherapists subscale, (M=10.03, SD=2.74) and women (M=8.52, SD= 2.94)  $t(82) = 2.84, p=0.01$ . Notable differences were detected between Black men and women with the physician's referral subscale, (M=6.21, SD=1.89, women (M=5.44, SD=2.00)  $t(81) = 1.96, p=0.03$ . Notable differences were detected between Black men and women with regards to both intrinsic and extrinsic barrier scores, (M=50.29, SD=11.42) women ( M=45.0, SD = 11.78)  $t(79)=1.96, p=0.03$ , and the extrinsic barriers subscale include, (M=39.74, SD=9.27) and women (M=39.74, SD=9.27)  $t(86)=1.71, p=0.05$ . These results suggest that Black men had increased barriers with regards to access to mental health care when it comes to stigma, beliefs about depression symptoms being normal, ageism, concerns about psychotherapists, physician referral concerns, as well as along with both increased barriers with regards to intrinsic and extrinsic items during COVID-19.

## Figure 12

### BMHSS-R Average Scores

Figure 12 BMHSS-R Average Scores

Figure 12 BMHSS-R Average Scores



### *Additional Descriptive Statistics*

Descriptive statistics for all psychological measures are presented in Table 5. Across the DASS-21 subscales, mean scores for depression ( $M = 8.38$ ,  $SD = 9.19$ ), anxiety ( $M = 9.77$ ,  $SD = 10.20$ ), and stress ( $M = 13.75$ ,  $SD = 11.18$ ) indicated considerable variability within the sample. Measures from the BMHSS-R demonstrated similarly broad score ranges across both intrinsic and extrinsic barriers. Intrinsic barriers showed the highest total score variability ( $M = 47.40$ ,  $SD = 11.82$ ), whereas extrinsic barriers reflected slightly lower but still substantial variability ( $M = 37.74$ ,  $SD = 10.27$ ). Subscales assessing Index of Race-Related Stress displayed moderate variability, with cultural racism ( $M = 28.14$ ,  $SD = 10.37$ ), institutional racism ( $M = 10.62$ ,  $SD = 7.40$ ), and individual racism ( $M = 13.19$ ,  $SD = 7.21$ ) each spanning a wide range of observed values.

Tests of normality were conducted using the Shapiro–Wilk statistic, which is the recommended procedure for evaluating distributional assumptions in samples of this size. The Shapiro–Wilk test indicated statistically significant deviations from normality for depression ( $W = .825, p < .001$ ), anxiety ( $W = .852, p < .001$ ), stress ( $W = .922, p < .001$ ), stigma ( $W = .894, p < .001$ ), knowledge and fear of psychotherapy ( $W = .940, p < .001$ ), belief about inability to find a psychotherapist ( $W = .955, p = .001$ ), belief that depressive symptoms are normal ( $W = .972, p = .025$ ), insurance or payment concerns ( $W = .962, p = .004$ ), ageism ( $W = .904, p < .001$ ), concerns about psychotherapist’s qualifications ( $W = .940, p < .001$ ), physician referral ( $W = .931, p < .001$ ), transportation concerns ( $W = .856, p < .001$ ), cultural racism ( $W = .883, p < .001$ ), institutional racism ( $W = .947, p < .001$ ), and individual racism ( $W = .950, p < .001$ ). Only the Help Seeking subscale met normality assumptions ( $W = .976, p = .061$ ). Although intrinsic barriers and extrinsic barriers showed nonsignificant Kolmogorov–Smirnov values, they demonstrated significant Shapiro–Wilk results and were therefore treated as non-normal ( $W = .975, p = .044$  and  $W = .969, p = .016$ , respectively). Based on these results, all psychological variables except Help Seeking were classified as non-normally distributed.

Table 7

*Descriptive Statistics for Depression, Anxiety, Stress, Mental Health Barriers, and Race-Related Stress Measures Among Black/African American Adults*

Table 7 Descriptive Statistics 1

Table 6 Descriptive Statistics for Depression, Anxiety, Stress, and Mental Health Barriers, Measures Among Black/African American Adults

Measurement	N	M	SD	Mode	Mdn	Q25	Q75	Min	Max
<b>DASS-21</b>									
Depression	104	8.38	9.19	.00	6.00	2.00	13.00	.00	36.00
Anxiety	104	9.77	10.20	.00	6.00	2.00	15.00	.00	42.00

Stress	104	13.75	11.18	.00	12.00	5.00	20.00	.00	42.00
<b>BMHSS-R</b>									
Help Seeking	104	8.86	2.36	10.00	9.00	7.00	11.00	4.00	15.00
Stigma	104	8.58	3.15	5.00	8.00	6.00	10.00	5.00	20.00
Knowledge and Fear of Psychotherapy	104	9.85	3.27	11.00	10.00	7.00	12.00	5.00	20.00
Belief about Inability to Find a Psychotherapist	104	10.25	3.39	11.00	11.00	8.00	13.00	5.00	19.00
Belief that Depressive Symptoms are Normal	104	9.88	2.68	11.00	10.00	8.00	11.00	4.00	16.00
Insurance/Payment Concerns	104	6.87	2.40	7.00	7.00	5.00	8.50	3.00	12.00
Ageism Concerns about Psychotherapist's Qualifications	104	7.83	2.54	5.00	8.00	5.00	10.00	5.00	17.00
Physician Referral Transportation Concerns	104	9.09	2.92	10.00	9.00	6.50	10.00	5.00	19.00
Intrinsic Barriers	104	5.72	1.99	6.00	6.00	4.00	7.00	3.00	11.00
Extrinsic Barriers	104	8.23	3.42	5.00	8.00	5.00	10.00	5.00	20.00
<b>IRRS-B</b>									
Cultural Racism	104	47.40	11.82	47.00 <sup>a</sup>	48.00	40.00	55.50	23.00	87.00
Institutional Racism	104	37.74	10.27	40.00	39.00	29.50	43.50	21.00	70.00
Individual Racism	104	28.14	10.37	36.00	31.00	22.00	36.00	.00	40.00
	104	10.62	7.40	.00	10.00	4.50	16.00	.00	24.00
	104	13.19	7.21	12.00	13.00	8.00	19.00	.00	24.00

*Note.* N = sample size. *M* = mean. *SD* = standard deviation. Mdn = median. Q25 and Q75 represent the 25th and 75th percentile values, respectively. Min and Max represent observed minimum and maximum scores. All variables were measured using validated self-report scales: DASS-21 (Depression, Anxiety, Stress Scales – 21-item version), BMHSS-R (Barriers to Mental Health Services Scale – Revised), and IRRS-B (Index of Race-Related Stress – Brief). For variables with multiple modes, the smallest mode is reported, as indicated by superscript a.

### ***Spearman's Correlation Analysis***

Spearman's rho correlation coefficients were computed to examine the associations among psychological distress, perceived mental health service barriers, and race-related stress variables. Nonparametric correlations were used because normality assumptions were not met

for most variables. Table 6 presents the bivariate correlation matrix, showing the direction and magnitude of associations among all study constructs.

- *Intercorrelations Among Psychological Distress Variables*

Strong positive correlations were observed among the DASS-21 subscales. Depression was highly correlated with anxiety ( $\rho = .787, p < .001$ ) and stress ( $\rho = .809, p < .001$ ).

Anxiety and stress were similarly strongly associated ( $\rho = .825, p < .001$ ). These coefficients indicate substantial overlap between the three dimensions of psychological distress in the sample.

- *Correlations Between Psychological Distress and Mental Health Service Barriers*

Depression, anxiety, and stress were each positively associated with multiple subscales of the BMHSS-R. Depression showed moderate correlations with intrinsic barriers ( $\rho = .453, p < .001$ ) and extrinsic barriers ( $\rho = .362, p < .001$ ), and stress demonstrated similar patterns with intrinsic barriers ( $\rho = .482, p < .001$ ) and extrinsic barriers ( $\rho = .370, p < .001$ ). Anxiety also correlated positively with intrinsic ( $\rho = .390, p < .001$ ) and extrinsic barriers ( $\rho = .323, p < .001$ ). These findings indicate that higher psychological distress was associated with greater perceived barriers to accessing mental health services.

- *Associations Among Mental Health Service Barriers*

Strong positive correlations were found among BMHSS-R subscales. Intrinsic and extrinsic barriers were strongly correlated ( $\rho = .809, p < .001$ ). Help seeking barriers demonstrated large correlations with intrinsic barriers ( $\rho = .710, p < .001$ ) and stigma ( $\rho = .486, p < .001$ ). Stigma was strongly associated with intrinsic barriers ( $\rho = .818, p < .001$ ) and extrinsic barriers ( $\rho = .732, p < .001$ ). Across the BMHSS-R, the subscales clustered tightly, indicating that multiple types of barriers tend to co-occur.

- *Correlations With Race-Related Stress*

Race-related stress variables were strongly correlated with each other, including cultural racism and individual racism ( $\rho = .771, p < .001$ ) and institutional racism and individual racism ( $\rho = .786, p < .001$ ). Psychological distress variables also showed small to moderate associations with race-related stress. Depression was positively associated with cultural racism ( $\rho = .283, p = .004$ ), institutional racism ( $\rho = .259, p = .008$ ), and individual racism ( $\rho = .295, p = .002$ ). Anxiety and stress followed similar patterns, with all correlations statistically significant. These associations indicate that higher perceptions of race-related stress were related to greater psychological distress.

Across measures, the correlation analysis showed that psychological distress, perceived mental health service barriers, and race-related stress were interconnected. The strongest relationships occurred among the DASS-21 subscales and among the BMHSS-R barrier domains, suggesting internal coherence within these constructs. Moderate associations between distress and barriers, and smaller but consistent associations between distress and race-related stress, indicate that adults reporting higher psychological distress also endorsed more obstacles to care and greater exposure to or perception of race-related stressors.

Table 8

*Spearman's Rho Correlation Matrix for Psychological Distress, Mental Health Service Barriers,*

Table 8 Spearman's Rho Correlation Matrix 1

Table 7 Spearman's Rho Correlation Matrix for Psychological Distress, Mental Health Service Barriers

	1	2	3	4	5	6	7	8	9	10	11	12
1	1											
2	.79***	1										
3	.81***	.83***	1									
4	.27**	.27**	.31**	1								
5	.27**	0.19	.27**	.49***	1							
6	.40***	.36***	.43***	.54***	.60***	1						
7	.41***	.36***	.49***	.50***	.68***	.70***	1					
8	.39***	.38***	.38***	.37***	.34***	.46***	.44***	1				
9	.26**	.27**	.29**	.39***	.36***	.41***	.51***	.48***	1			
10	.19*	0.12	0.17	.45***	.72***	.64***	.58***	.33***	.41***	1		
11	.26**	0.17	.25*	.42***	.73***	.74***	.66***	.37***	.42***	.73***	1	
12	.32**	.32**	.42***	.45***	.57***	.61***	.66***	.45***	.40***	.59***	.59***	1
13	.24*	.30**	.28**	.24*	.48***	.43***	.48***	.26**	.42***	.54***	.46***	.48***
14	.45***	.39***	.48***	.71***	.82***	.83***	.86***	.63***	.52***	.69***	.75***	.72***
15	.36***	.32***	.37***	.49***	.73***	.72***	.73***	.48***	.67***	.83***	.80***	.75***
16	.28**	.29**	.33***	.22*	0.1	.32**	.20*	.24*	.16	0.07	0.14	0.12
17	.26**	.27**	.31**	.24*	.23*	.49***	.33***	.21*	.15	.23*	.35***	.26**
18	.29**	.32***	.39***	.19	.17	.40***	.26**	.25*	.13	0.1	.26**	.27**

Note. N = 104. Values represent Spearman's rho correlation coefficients. Variables are numbered as follows: 1 = Depression, 2 = Anxiety, 3 = Stress, 4 = Help Seeking, 5 = Stigma, 6 = Knowledge and Fear of Psychotherapy, 7 = Belief about Inability to Find a Psychotherapist, 8 = Belief that Depressive Symptoms are Normal, 9 = Insurance or Payment Concerns, 10 = Ageism, 11 = Concerns about Psychotherapist's Qualifications, 12 = Physician Referral, 13 = Transportation Concerns, 14 = Intrinsic Barriers, 15 = Extrinsic Barriers, 16 =

## Gender Differences in Barriers of Mental Health Services Revised (BHMSS-R)

### MANOVA Analysis

A MANOVA multivariate test was also conducted on the Barriers of Mental Health Services revised ten subscales. Assumptions for MANOVA were evaluated before

analysis. Bartlett's test of sphericity indicated that the residual covariance matrix differed significantly from an identity matrix,  $\chi^2(54) = 655.46, p < .001$ , demonstrating that the BMHSS-R subscales were sufficiently intercorrelated to justify a multivariate approach. This finding aligns with the theoretical structure of the BMHSS-R, in which subscales are designed to represent related facets of perceived help-seeking barriers.

Box's M test assessing equality of covariance matrices across gender groups was statistically significant,  $M = 84.14, F(55, 19804.58) = 1.35, p = .042$ ; however, given the known sensitivity of Box's M to minor deviations from multivariate normality and to unequal group sizes, robust multivariate statistics such as Pillai's Trace and Wilks' Lambda were used to interpret the results. Homogeneity of error variances was supported for all ten dependent variables, with Levene's tests ranging from  $F(1, 102) = 0.003, p = .959$  (Depressive Symptoms Normalization) to  $F(1, 102) = 0.97, p = .328$  (Inability to Find Psychotherapist), demonstrating that variances did not differ significantly between gender groups. Inspection of residual plots showed no meaningful violations of linearity or multivariate normality. Overall, the assumption checks confirmed that the data were appropriate for conducting MANOVA on the ten BMHSS-R subscales.

A one-way MANOVA was conducted to examine whether perceived barriers to mental health care differed by gender across ten BMHSS-R subscales. The multivariate effect of gender was not statistically significant, Wilks'  $\Lambda = .908, F(10, 93) = 0.937, p = .503, \text{partial } \eta^2 = .092$ , indicating no overall gender differences in the combined barrier profile. Follow-up univariate analyses revealed two significant effects. Men reported higher stigma ( $M = 9.50, SD = 3.02$ ) than women ( $M = 8.05, SD = 3.12$ ),  $F(1, 102) =$

5.37,  $p = .022$ , partial  $\eta^2 = .050$ , and greater concerns about psychotherapist qualifications ( $M = 10.03$ ,  $SD = 2.74$ ) compared to women ( $M = 8.55$ ,  $SD = 2.90$ ),  $F(1, 102) = 6.55$ ,  $p = .012$ , partial  $\eta^2 = .060$ . All remaining subscales, including help seeking, knowledge and fear of psychotherapy, inability to find a psychotherapist, depressive symptom beliefs, insurance/payment concerns, ageism, physician referral, and transportation, showed no statistically significant gender differences (all  $ps > .05$ ), although men consistently reported slightly higher mean scores across most domains. Overall, the pattern suggests that while most perceived barriers were comparable between genders, men exhibited moderately greater stigma-related concerns and more doubts regarding therapist qualifications.

Table 9.

*Descriptive Statistics for BMHSS-R Subscales by Gender*

Table 9 Descriptive Statistics for BMHSS 1

Table 8 Descriptive Statistics for BMHSS-R Subscales by Gender

	Gender			
	Man ( $n = 38$ )		Woman ( $n = 66$ )	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Help Seeking	9.32	2.47	8.59	2.27
Stigma	9.50	3.02	8.05	3.12
Knowledge & Fear	10.50	3.13	9.47	3.31
Inability to Find Psychotherapist	11.03	3.24	9.80	3.42
Depressive Symptom Normalization	9.97	2.69	9.82	2.69
Insurance/Payment	6.97	2.44	6.82	2.39
Ageism	8.45	2.52	7.47	2.51
Therapist Qualifications	10.03	2.74	8.55	2.90

Physician Referral	6.21	1.89	5.44	2.00
Transportation	8.37	3.31	8.15	3.50

*Note.* N = sample size. *M* = mean. *SD* = standard deviation

Table 10.

*Multivariate and Univariate Test Results for Gender Differences in BMHSS-R Subscales*

Table 10 Multivariate / Univariate Test 1

Table 9 Descriptive Statistics for BMHSS-R Subscales by Gender

Outcome	<i>Wilks' A</i>	<i>F</i>	<i>df (df1, df2)</i>	<i>p</i>	<i>Partial η<sup>2</sup></i>
Multivariate test (10 DVs)	0.908	0.937	10, 93	.503	0.092
Help Seeking	-	2.3	1, 102	.133	0.022
Stigma	-	5.37	1, 102	.022	0.05
Knowledge & Fear	-	2.43	1, 102	.122	0.023
Inability to Find Psychotherapist	-	3.2	1, 102	.076	0.03
Depressive Symptom Normalization	-	0.08	1, 102	.777	0.001
Insurance/Payment	-	0.1	1, 102	.752	0.001
Ageism	-	3.65	1, 102	.059	0.035
Therapist Qualifications	-	6.55	1, 102	.012	0.06
Physician Referral	-	3.73	1, 102	.056	0.035
Transportation	-	0.1	1, 102	.757	0.001

*Note.* *Wilks' A* represents the multivariate test statistic for the combined dependent variables. Univariate tests are shown for each dependent variable following the multivariate analysis. *F* values reflect the ratio of explained to unexplained variance, with degrees of freedom reported as (*df*<sub>1</sub>, *df*<sub>2</sub>). *Partial η<sup>2</sup>* indicates the proportion of variance in each outcome explained by gender after accounting for other variables in the model.

***Gender Differences in Composite Help-Seeking Barriers (Intrinsic and Extrinsic)***

Bartlett's test of sphericity indicated that the dependent variables were sufficiently correlated for a multivariate test,  $\chi^2(2) = 118.03, p < .001$ , consistent with the expected association between intrinsic and extrinsic barrier composites. Box's M test supported equality of covariance matrices across gender groups,  $M = 1.15, F(3, 191695.76) = 0.37$ ,

$p = .773$ , indicating no violation of multivariate homogeneity. Levene's tests confirmed homogeneity of variances for both intrinsic barriers,  $F(1, 102) = 0.35, p = .555$ , and extrinsic barriers,  $F(1, 102) = 1.97, p = .164$ , demonstrating that group variances were statistically equivalent. Examination of residual plots and spread-versus-level patterns revealed no meaningful departures from linearity or normality. Together, these diagnostics indicated that the data met the assumptions required for conducting MANOVA on intrinsic and extrinsic barrier scores.

A one-way MANOVA was conducted to examine whether gender differences were present in overall perceived barriers to mental health care. The multivariate effect of gender was not statistically significant, Wilks'  $\Lambda = .964, F(2, 101) = 1.88, p = .158$ , partial  $\eta^2 = .036$ , indicating no overall difference in the combined pattern of intrinsic and extrinsic barriers. Follow-up univariate tests showed that men reported marginally higher intrinsic barriers ( $M = 50.32, SD = 11.40$ ) than women ( $M = 45.73, SD = 11.82$ ), although this difference did not reach statistical significance,  $F(1, 102) = 3.73, p = .056$ , partial  $\eta^2 = .035$ . Similarly, men also reported somewhat higher extrinsic barriers ( $M = 40.03, SD = 9.36$ ) compared to women ( $M = 36.42, SD = 10.60$ ), but again the difference was nonsignificant,  $F(1, 102) = 3.03, p = .085$ , partial  $\eta^2 = .029$ . Overall, these results indicate that men and women did not significantly differ in their perceived mental health access barriers at the composite level, although both domains showed small non-significant elevations among men.

Table 11

*Descriptive Statistics for Intrinsic and Extrinsic Barriers by Gender Indicate Greater Perceived Barriers.*

Table 11 Descriptive Statistics 1

Table 10 Descriptive Statistics for Intrinsic and Extrinsic Barriers by Gender

	Gender			
	Man ( <i>n</i> = 38)		Woman ( <i>n</i> = 66)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Intrinsic Barriers	50.32	11.40	45.73	11.82
Extrinsic Barriers	40.03	9.36	36.42	10.60

*Note.* *N* = sample size. *M* = mean. *SD* = standard deviation

Table 12.

*Multivariate and Univariate Test Results for Gender Differences in Intrinsic and Extrinsic Barriers*

Table 12 Multivariate/ Univariate Test 1

Table 11 Multivariate and Univariate Test Results for Gender Differences in Intrinsic and Extrinsic Barriers

Outcome	<i>Wilks' A</i>	<i>F</i>	<i>df (df1, df2)</i>	<i>p</i>	<i>Partial η<sup>2</sup></i>
Multivariate test (2 DVs)	0.964	1.878	2, 101	0.158	0.036
Intrinsic Barriers	-	3.73	1, 102	0.056	0.035
Extrinsic Barriers	-	3.03	1, 102	0.085	0.029

*Note.* *Wilks' A* represents the multivariate test statistic for the combined dependent variables. Univariate tests are shown for each dependent variable following the multivariate analysis. *F* values reflect the ratio of explained to unexplained variance, with degrees of freedom reported as (*df*<sub>1</sub>, *df*<sub>2</sub>). *Partial η<sup>2</sup>* indicates the proportion of variance in each outcome explained by gender after accounting for other variables in the model.

$F(1, 102) = 0.003, p = .959$  (Depressive Symptoms Normalization) to  $F(1, 102) = 0.97, p = .328$  (Inability to Find Psychotherapist), demonstrating that variances did not

differ significantly between gender groups. Inspection of residual plots showed no meaningful violations of linearity or multivariate normality. Overall, the assumption checks confirmed that the data were appropriate for conducting MANOVA on the ten BMHSS-R subscales.

A one-way MANOVA was conducted to examine whether perceived barriers to mental health care differed by gender across ten BMHSS-R subscales. The multivariate effect of gender was not statistically significant, Wilks'  $\Lambda = .908$ ,  $F(10, 93) = 0.937$ ,  $p = .503$ , partial  $\eta^2 = .092$ , indicating no overall gender differences in the combined barrier profile. Follow-up univariate analyses revealed two significant effects. Men reported higher stigma ( $M = 9.50$ ,  $SD = 3.02$ ) than women ( $M = 8.05$ ,  $SD = 3.12$ ),  $F(1, 102) = 5.37$ ,  $p = .022$ , partial  $\eta^2 = .050$ , and greater concerns about psychotherapist qualifications ( $M = 10.03$ ,  $SD = 2.74$ ) compared to women ( $M = 8.55$ ,  $SD = 2.90$ ),  $F(1, 102) = 6.55$ ,  $p = .012$ , partial  $\eta^2 = .060$ . All remaining subscales, including help seeking, knowledge and fear of psychotherapy, inability to find a psychotherapist, depressive symptom beliefs, insurance/payment concerns, ageism, physician referral, and transportation, showed no statistically significant gender differences (all  $ps > .05$ ), although men consistently reported slightly higher mean scores across most domains. Overall, the pattern suggests that while most perceived barriers were comparable between genders, men exhibited moderately greater stigma-related concerns and more doubts regarding therapist qualifications.

Table 13.

*Descriptive Statistics for BMHSS-R Subscales by Gender*

Table 13 Descriptive Statistics 1

Table 12 Descriptive Statistics for BMHSS-R Subscales by Gender

	Gender			
	Man ( <i>n</i> = 38)		Woman ( <i>n</i> = 66)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Help Seeking	9.32	2.47	8.59	2.27
Stigma	9.50	3.02	8.05	3.12
Knowledge & Fear	10.50	3.13	9.47	3.31
Inability to Find Psychotherapist	11.03	3.24	9.80	3.42
Depressive Symptom Normalization	9.97	2.69	9.82	2.69
Insurance/Payment	6.97	2.44	6.82	2.39
Ageism	8.45	2.52	7.47	2.51
Therapist Qualifications	10.03	2.74	8.55	2.90
Physician Referral	6.21	1.89	5.44	2.00
Transportation	8.37	3.31	8.15	3.50

*Note.* *N* = sample size. *M* = mean. *SD* = standard deviation

Table 14.

*Multivariate and Univariate Test Results for Gender Differences in BMHSS-R Subscales*

Outcome	<i>Wilks' Λ</i>	<i>F</i>	<i>df</i> ( <i>df1</i> , <i>df2</i> )	<i>p</i>	<i>Partial η</i> <sup>2</sup>
Multivariate test (10 DVs)	0.908	0.937	10, 93	.503	0.092
Help Seeking	-	2.3	1, 102	.133	0.022
Stigma	-	5.37	1, 102	.022	0.05
Knowledge & Fear	-	2.43	1, 102	.122	0.023
Inability to Find Psychotherapist	-	3.2	1, 102	.076	0.03
Depressive Symptom Normalization	-	0.08	1, 102	.777	0.001
Insurance/Payment	-	0.1	1, 102	.752	0.001
Ageism	-	3.65	1, 102	.059	0.035
Therapist Qualifications	-	6.55	1, 102	.012	0.06
Physician Referral	-	3.73	1, 102	.056	0.035
Transportation	-	0.1	1, 102	.757	0.001

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*Note.* *Wilks' A* represents the multivariate test statistic for the combined dependent variables. Univariate tests are shown for each dependent variable following the multivariate analysis. *F* values reflect the ratio of explained to unexplained variance, with degrees of freedom reported as (*df*<sub>1</sub>, *df*<sub>2</sub>). *Partial η*<sup>2</sup> indicates the proportion of variance in each outcome explained by gender after accounting for other variables in the model.

### Summary

In this chapter, I examined analysis results related to both demographic and research questions. Findings identified demographic descriptive and inferential statistics. In this study, the demographic survey analysis showed respondents who experienced COVID-19, and the sample who did not experience or was infected by COVID-19 personally. Descriptive statistic was conducted on the demographic question which asked about positive attitudes on receiving mental health care if they were a different race or ethnicity between Black women and men.

The analysis detected differences between men and women in that 39% of men versus 32% of women believed that being a different race or ethnicity would make a difference in receiving mental health treatment. The research also indicated that differences were found in DASS-21 subscales of depression, anxiety, and stress between Black women and Black men. For example, Black men scored higher within the moderate range for depression, anxiety and stress symptoms than women, but the depression, anxiety, and stress graphs also indicate that Black women experienced higher depression scores when impacted by severe or very severe level of depression, anxiety and stress symptoms. With this being stated however, no statistical significance was detected in DASS-21 subscales with this sample population.

I also examined descriptive statistics for the whole data set comprising of range (maximum – minimum), mean and standard deviation for the ten subscales of BMHSS-R including intrinsic and extrinsic barriers. In addition, Cronbach's alphas were examined on the ten BMHSS-R subscales. The Cronbach's of 0.7 and higher indicates stronger internal consistency of measures. This output illustrated that all but help-seeking had acceptable (0.7), good (0.8) and excellent ( $\geq 0.9$ ) inter-consistency scores. An independent t-tests with an assumption of unequal variance were completed to examine the differences in average scores for BMHSS-R for men and women. The unequal variance assumption was used because of a large sample size differences between men and women. Differences were observed between Black men and women. These results suggest that Black men had increased barriers with regards to access to mental health care when it comes to stigma, beliefs about depression symptoms being normal, ageism, concerns about psychotherapists, physician referral concerns, as well as along with both statistically significant barriers with regards to intrinsic and extrinsic items during COVID-19 than Black women. A one-way MANOVA was also conducted to examine whether gender differences were present in overall perceived barriers to mental health care. The multivariate effect of gender was not statistically significant, Wilks'  $\Lambda = .964$ ,  $F(2, 101) = 1.88$ ,  $p = .158$ , partial  $\eta^2 = .036$ , indicating no overall difference in the combined pattern of intrinsic and extrinsic barriers. Follow-up univariate tests showed that men reported marginally higher intrinsic barriers ( $M = 50.32$ ,  $SD = 11.40$ ) than women ( $M = 45.73$ ,  $SD = 11.82$ ), although this difference did not reach statistical significance,  $F(1, 102) = 3.73$ ,  $p = .056$ , partial  $\eta^2 = .035$ . Similarly, men also reported

somewhat higher extrinsic barriers ( $M = 40.03$ ,  $SD = 9.36$ ) compared to women ( $M = 36.42$ ,  $SD = 10.60$ ), but again the difference was nonsignificant,  $F(1, 102) = 3.03$ ,  $p = .085$ , partial  $\eta^2 = .029$ . A one-way MANOVA was then conducted to examine whether perceived barriers to mental health care differed by gender across ten BMHSS-R subscales. The multivariate effect of gender was not statistically significant, Wilks'  $\Lambda = .908$ ,  $F(10, 93) = 0.937$ ,  $p = .503$ , partial  $\eta^2 = .092$ , indicating no overall gender differences in the combined barrier profile. Follow-up univariate analyses revealed two significant effects. Men reported higher stigma ( $M = 9.50$ ,  $SD = 3.02$ ) than women ( $M = 8.05$ ,  $SD = 3.12$ ),  $F(1, 102) = 5.37$ ,  $p = .022$ , partial  $\eta^2 = .050$ , and greater concerns about psychotherapist qualifications ( $M = 10.03$ ,  $SD = 2.74$ ) compared to women ( $M = 8.55$ ,  $SD = 2.90$ ),  $F(1, 102) = 6.55$ ,  $p = .012$ , partial  $\eta^2 = .060$ . All remaining subscales, including help seeking, knowledge and fear of psychotherapy, inability to find a psychotherapist, depressive symptom beliefs, insurance/payment concerns, ageism, physician referral, and transportation, showed no statistically significant gender differences (all  $ps > .05$ ), although men consistently reported slightly higher mean scores across most domains. Overall, the pattern suggests that while most perceived barriers were comparable between genders, men exhibited moderately greater stigma-related concerns and more doubts regarding therapist qualifications.

In Chapter five, I will review study approaches, purpose, and how hypothesis testing and findings impact past and present research in this field. I will also address

future recommendations, implications of study, limitations, conclusion, and possible research for future studies.

## Chapter 5: Discussion, Conclusions, and Recommendations

### **Introduction**

An important aspect of this quantitative study focuses on utilizing statistical analysis. This format of analysis provided a solid empirical framework. In addition, through consistent numerical data-driven practices, I was able to urgently address this important topic of gender differences between Black women and Black men confronted with mental health concerns during a health crisis like COVID-19. I also explored the differences in access to mental health care and mental health concerns when gender and race/ethnicity intersect during a crisis. One significant goal of this study was to further increase the knowledge of insight and awareness to counselors, counselor educators and other mental health professionals. This goal involved the identification of perceived barriers and additional strategies of providing advocacy for better mental health care engagement practices and outcomes for this population.

This study employed a quantitative design and was analyzed using descriptive and inferential statistics. A quantitative approach was vital in this research study. It contributed to measuring chosen variables while answering questions related to hypothesis testing, as well as its capacity to understand trends and patterns of a population, which can then inform effective strategies for the future (Lim, 2024). Participants for this online study were recruited through online searches and email requests to identify Black leadership organizations for their support and collaboration. The invitation requested participants to complete an online survey to explore possible gender differences between Black women and Black men confronted with mental health

concerns, as well as the differences when gender and race/ethnicity intersect in accessing mental health care during COVID-19. Data was collected using the online survey method and analyzed using the Statistical Package of Social Sciences (SPSS) software.

### **Research Questions**

RQ1: Do the intersecting variables of gender identification and mental health concerns (specifically depression and anxiety) differ between Black women and men during the COVID-19 health crisis?

RQ2: Are there differences between how Black women and men accessed mental health care when gender and race/ethnicity intersected during the COVID-19 health crisis?

H<sub>1</sub>: There are gender differences between Black women and Black men in accessing mental health care during a health crisis like COVID-19. Additionally, there are significant differences in mental health concerns like depression and anxiety.

H<sub>0</sub>: There are no gender differences between Black women and Black men in accessing mental health care during a health crisis like COVID-19. Additionally, there are no differences in mental health concerns like depression and anxiety.

### **Interpretation of the Findings**

As mentioned within the first hypothesis question, it was posited that there would be gender differences between Black women and Black men in accessing mental health care during a health crisis of COVID-19 and additionally, there would be significant differences in mental health concerns like depression and anxiety. This study examined a

44 item self-report measure: Barriers to Mental Health Services scale-R completed by respondents. The subscales included transportation concerns, physician referral, help-seeking attitudes, stigma, knowledge and fear of psychotherapy, belief about inability to find a psychotherapist, belief that depressive symptoms are normal, insurance and payment concerns, ageism, concerns about psychotherapist's qualifications. Findings of the study revealed that while the multivariate effect of gender was not statistically significant across ten BMHSS-R subscales a follow up univariate analyses revealed two significant effects gender between Black women and Black men in accessing mental health care/ treatment during the health crisis of COVID-19. Men reported higher stigma ( $M = 9.50, SD = 3.02$ ) than women ( $M = 8.05, SD = 3.12$ ),  $F(1, 102) = 5.37, p = .022$ , partial  $\eta^2 = .050$ , and greater concerns about psychotherapist qualifications ( $M = 10.03, SD = 2.74$ ) compared to women ( $M = 8.55, SD = 2.90$ ),  $F(1, 102) = 6.55, p = .012$ , partial  $\eta^2 = .060$ . These results support the hypothesis and suggest that Black men may experience increased barriers with regard to accessing mental health care compared to Black women.

This study also assessed the intersecting variables of gender identification and mental health concerns (specifically depression and anxiety, and stress) during COVID-19. It was hypothesized that there would be significant differences in mental health concerns like depression, anxiety, and stress between Black women and Black men. This study used the DASS-21 measure to examine these three self-report subscales, with each scale consisting of seven items. Lovibond (1995), the author of the measure,

acknowledged that these three subscales expound on negative emotional states, including feelings of depression, such as

dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia, and inertia. The anxiety scale assessed autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic nonspecific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable / over-reactive, and impatient. (pg.2).

The study then revealed that gender differences were found in depression, anxiety, and stress subscales between Black men and Black women when observing the descriptive statistics. These findings showed that Black men scored higher than Black women on all three subscales when observing the moderate range categories. In addition, the study also revealed that Black women scored higher than Black men on all subscales when observing severe to extremely severe subscale score categories. However, while these important differences in trends were recognized, when the independent sample t-test with assumption of unequal variance was conducted on depression, anxiety, and stress subscales to check on significance in differences of mean between scores for Black men and Black women during COVID-19, the null hypothesis was assumed as there was insufficient evidence to support the hypothesis of statistical significant difference in depression, anxiety or stress subscales. Likewise, A one-way MANOVA was conducted to examine whether emotional distress including depression, anxiety and stress subscales differed by gender. The multivariate effect of gender was not statistically significant,

Wilks'  $\Lambda = .984$ ,  $F(3, 100) = 0.533$ ,  $p = .661$ , partial  $\eta^2 = .016$ , indicating no overall group differences across the combined outcomes of depression, anxiety, and stress.

Follow-up univariate analyses were consistent with the multivariate findings.

### **Discussion**

Overall, the findings of this current study support several previous studies that examined the barriers that mental health treatment and mental health concerns have had on the Black population. For example, Joseph et al (2024) study pointed out the critical underrepresentation of Black men specifically, when examining Black men participating in mental health resources like outpatient services for mental health or medication management. The research also found that Black men respond more positively and experience better treatment outcomes when treated by providers who look like them ethnically. This corroborates this study's findings of a strong correlation between concerns about psychotherapists' qualifications and the belief about inability to find a psychotherapist ( $r=0.77$ ). This study also found that the subscales of depression, anxiety, and stress tables suggested that Black women experienced higher trend of scores that ranked between severe or very severe level on all three DASS-21 subscales of depression, anxiety, and stress. A recent study of Black women by Kalinowski et al (2022) has correlated compounding stress with unfavorable mental and physical health results, which they suggest COVID-19 only intensified. This research also noted how Black women appear to internalize certain dysfunctional schemas such as Strong Black Woman Syndrome and Superwoman Syndrome which encourages this population to present themselves as resilient, unbreakable or tough, and able to endure higher levels of stress or

strain without ever being impacted by the weight, and this understanding may account for the elevated subscale ranges of depression, anxiety, and stress among this sample of Black women specifically in this study.

As mentioned in an earlier portion of this study data analysis, Black men were also found to experience significantly higher gender differences than Black women regarding stigma and concerns about psychotherapist qualifications. Shaw et al (2024) pointed to recent studies that continue to highlight concerns of the adverse effects of mistrust due to the historical and cultural abuses experienced by Black men that can perpetuate “persistent treatment inequities, ingrained prejudices in mental health care and limited access to mental health therapies” (pg. 650). Smith-Woods et al (2025) further explained that due to the lived experience of the Black man, it becomes difficult for them to trust professionals of the mental health care system. This mistrust ultimately results in this population silencing their trauma and leaving their mental health concerns unaddressed.

Other research has also pointed to the idea of race related stress as a possible reason for this gap in continual unmet mental health needs in Black men (Uwire, 2022). Loiseau et al (2025) completed a study between gendered racism and psychological distress in Black men and suggest that despite “experiencing male privilege in patriarchal society, Black men appear to have also had discriminatory practices as a function of their race and gender, and because of this their oppression is also gendered, and therefore may experience more race related stress than Black women” (pg.224). It is suggested that these negative effects can result in unhealthy coping strategies, and ultimately negative

mental health outcomes for Black men. These mentioned factors are consistent with this study findings and may account for the two statistically significant effects found in the follow up univariate analysis of the BMHSS subscales.

### **Limitations of the Study**

This study encountered several limitations that should be considered while observing findings. The sample in this study focused exclusively on African Americans participants from Black communities in different regions across the United States of America. Therefore, applicable findings that can be generalized may be restrictive to the scope of this specific demographic. Secondly, the survey measure that was given to respondents was conducted specifically from online sources by sending out a QR code or URL from the survey monkey. This process may deter a respondent from participating and self-reporting their own views due to not having access to basic internet services or electronic devices to complete the survey.

The data collected from this study was conducted utilizing a self-reported format which could pose some vulnerability to recall bias. Another limitation of the study is that a technical glitch prevented respondents from completing the second page on the COVID-19 Impact scale, which prevented further analysis of this scale. The demographic questionnaire was, however, able to capture the necessary COVID-19 variables for this study. Lastly, this sample population included many more females who participated than male participants, which could introduce bias and impact the study's outcomes. Future directions for this research could include obtaining a larger male participant sample. Additionally, future research could add to these findings by exploring other cultures from

different regions of the world among the African diaspora to understand gender differences when it comes to accessing mental health treatment and mental health outcomes during a crisis like COVID-19.

Despite the limitations, this study not only supported similar studies related to this content but also provided valuable insight of how gender differences, and the intersecting factors of depression, anxiety, stress, and lack of access to and mental health care/ treatment during COVID-19 impacted Black men and women. Additionally, the scope of how to apply this study's findings to current clinical practice is addressed. Future work related to this study supports the need for ongoing development of improving access to mental health care and treatment for Black women and men across the country, and possibly around the world.

### **Recommendations**

#### **Closing The Gap in Access to Mental Health Care in Black Communities**

This study highlighted the continual barriers Black women and Black men experienced when being confronted with mental health concerns or accessing mental health treatment during the pandemic era of COVID-19. These findings greatly emphasize and deepen the need for improving barriers to accessing mental health treatment for Black men and reducing severe and extremely severe ranges of mental health concerns such as depression, anxiety and stress symptoms among Black women. Recommended initiatives from this study include improving mental health awareness and mental health education within Black communities. Additionally, developing culturally responsive engagement practices for Black men and Black women should also be explored.

Actionable steps for improving mental health education and awareness within Black communities should include creating safe spaces for mental health by selecting common community areas where Black men regularly attend.

Safe space locations can include barber shops, grocery stores, recreational centers, salons, cigar lounges, and churches to place mental health education materials and outreach brochures. These pamphlets could simply clarify the importance of openly expressing mental health concerns and reinforcing the importance of seeking mental health treatment when necessary. Culturally tailored engagement practices should involve utilizing Black mental health professionals trained in cultural responsiveness with a trauma informed approach. These interventions could increase counselors' visibility, reinforce a trusting and welcoming environment where stigma and questions concerning psychotherapists can be addressed. Moreover, healthy conversations that foster dialogue on other mental health topics by licensed mental health counselors could be introduced. Hankerson et al (2015) also pointed this importance and noted that Black men practice help seeking behaviors from individuals with whom they share familiar traits and qualities, and tend to focus on using more relaxed, informal, and casual social resources when experiencing mental health concerns like family connections and faith-based organizations including churches within their communities than using professional networks. Additionally, Bauer et al (2024) completed a recent study on mental health attitudes, norms, beliefs and experiences among young Black men. This study suggests that interventions and training programs such as Mental health first aid and or Applied Suicide Interventions Skills training (ASIST) can be effective to Black communities. This

strategy involves utilizing other family members and peer groups to standardize conversations regarding mental health. Even more importantly, this technique could be beneficial in bridging the gap and increase access and utilization in mental health care and counseling services among Black men and women within the United States.

### **How Mental Health Professionals Can Address COVID-19 Impact**

Loeb et al (2021) discussed the importance of mental health professionals leading their communities in confronting barriers and advocating for the improvement in access to mental health care and treatment for Black women and Black men as well as other marginalized communities. One recommendation involves counselors and other mental health professionals to contribute to building wrap around therapy programs that can assist in providing integrated provider care in areas that have a lack of resources. Recent Research suggests that offering ongoing telehealth sessions for Black men and women post COVID-19 pandemic in addition to developing multidisciplinary mental health teams with multicultural competence is also favorable for the purpose of addressing any gaps in services, as well as strengthening the therapeutic alliance that could assist in bridging the divergence of mental health access between Black men and women during COVID -19 (Loeb et al, 2021).

Another recommendation gained from this research to address barriers experienced by Black women and men could include incorporating University programs across the country to implement and teach culturally responsive approaches within counseling and psychology graduate programs to counselors in training which integrates cultural awareness strategies along with active listening principles that appreciate the

voice and values of the individual (Mathur & Rodriguez, 2021). Demetrius (2024) noted several strategies that counseling educator programs as well as what Licensed Professional counselors can do to assist in increasing access to mental health care and reducing mental health concerns among Black communities. Black licensed professional counselor supervisors at participating Universities, can begin by creating meaningful connections with community organizations, as well as provide clinical internship opportunities for the purpose of enhancing access to mental health treatment and reducing mental health concerns and preventing the rise in rates of completed suicides among this demographic. Secondly, encouraging individuals within Black communities in both urban and rural areas, who have benefited from individual or group counseling to speak to its positive impact may help in changing the narrative that seeking mental health treatment is a weakness to a strength, especially for Black men. A third actionable step involves increasing visibility through marketing. This advertisement could emphasize the need for counselor educators within urban and rural communities and could be helpful in producing individuals among this demographic to obtain careers within the counseling field (Demetrius, 2024). These pendulum shifts may not only begin to address these important factors but help to reverse the current negative stigma associated with barriers in accessing mental health care and mental health concerns, as well as reduce the belief that moderate and severe or extreme depression symptoms are normal.

### **Implications**

This research examined the underexplored topic of gender differences and access to mental health care between Black men and women impacted by COVID-19. This

particular study was also designed to amplify the current understanding of barriers and mental health concerns found in existing literature within Black communities. The self-reported responses revealed by participants within this research reflected a few critical implications. One implication includes the importance of connecting with both Black men and Black women through the vital practice of actively listening from a cultural context in reducing barriers in accessing mental health treatment.

In addition, understanding that the lived experiences and underlying historical and present needs within this unique population should be viewed from an ongoing process and lens of not only cultural competence but also cultural humility. This involves interventions such as a genuine openness to learning from others, the acknowledgement of the existence of power imbalances and the willingness to challenge it, as well as the ability and capacity to understand that self-reflection must extend to how one's own biases can impact Black communities (Ungvarsky, 2024). This primary practice of respect and dignity from organizations and other individuals as a whole, is a crucial and beneficial key intervention toward seeking to foster better communication and better relationships with this specific demographic.

### **Conclusion**

In conclusion, this study adds to the current literature on the significant impact of gender differences between Black women and Black men during COVID-19. This study specifically examined the intersectionality of mental health concerns including depression, anxiety, and stress, and access to mental health care. This research illuminated the serious differential gaps and barriers that continues to face Black women

and men which increases underutilization among this population. Statistical analysis from this study revealed factors and consequences from both elevated intrinsic and extrinsic mental health barriers for Black men that included significant stigma concerns, and concerns about psychotherapist qualifications, in addition to high intercorrelations concerning beliefs about depression symptoms being normal, ageism, and physician referral concerns than Black women during the crisis of COVID-19. Descriptive statistics findings highlighted that Black men scored higher than Black women on all three subscales when observing the moderate range categories. However, the study also revealed that Black women scored higher than Black men on all subscales when observing severe to extremely severe subscale score categories. These factors have decreased access to mental health care, and these beliefs and attitudes made treatment for this demographic unfavorable during the COVID-19 crisis.

Overall, the correlational analyses demonstrated a coherent and theoretically consistent pattern in which psychological distress, and mental health service barriers, were systematically interrelated. Strong associations among DASS-21 subscales underscored the interconnected nature of depression, anxiety, and stress. Furthermore, moderate positive correlations between psychological distress and perceived access barriers indicate that individuals experiencing greater emotional distress also reported more obstacles to accessing and engaging in mental health services. The observed associations between distress barriers to access reinforce longstanding empirical evidence showing that factors including stigma remains a salient predictor of psychological burden among Black communities. Importantly, the tight clustering among BMHSS-R barrier

subscales suggests that Black adults often encounter multiple, overlapping forms of structural, instrumental, and attitudinal barriers simultaneously, rather than in isolation.

The findings of this study recommend retraining in a collection of culturally responsive strategies by universities and counseling organizations to counselors in training, counselors, and other mental health professionals. Also, creating safe space locations within Black communities to educate on mental health awareness, and utilizing active listening principles that appreciate the voice and values of this population is vital. Other advocacy strategies that can be utilized by counselors, counselor educators and other mental health professionals to increase utilization of services include offering optional formats of service like using telehealth as well as introducing peer lead programs like mental health aid or ASSIST to these communities. In conclusion, this research suggests providing education to Black women and men on skills of how to identify or respond to signs of poor mental health, as well as utilizing Black mental health providers to contribute to building wrap around mental health therapy programs can improve utilization services in Black communities around the country and possibly around the world.

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Appendix A: Screening Questions/Demographic Questionnaire

**Screening Questions**

1. Are you at least 18 years or older?
  1. Yes
  2. No
  
2. Do you Identify as Black or African American?
  1. Yes
  2. No

**Demographic Questionnaire for Dissertation (Appendix A)**

1. What gender do you currently identify with?
  - A. Agender
  
  - B. Gender Fluid
  
  - C. Gender queer
  
  - D. Gender Questioning
  
  - E. Man
  
  - F. non-binary
  
  - G. Woman
  
  - H. I prefer not to answer
  
2. How old are you?

- A. 18-24 years old
- B. 25-34 years old
- C. 35-44 years old
- D. 45-54 years old
- E. 55-64 years old
- F. 65+ years old

3. What is your ethnic background?

- A. White/Caucasian
- B. Asian
- C. Native Hawaiian or Pacific Islander
- D. Hispanic or Latino
- E. African American
- F. Indigenous, Aboriginal, or First Nations
- G. Prefer not to answer

4. What area of the United States do you currently live in?

- A. Midwest
- B. Northeast
- C. South
- E. West

F. United States Territory

G. Outside of the United States or United States Territory

H. I prefer not to answer

5. What is the highest level of education you have completed?

A. Less than High School

B. High school Diploma / GED)

C. Some college (no degree)

D. Technical certification

E. Associate degree (2-year)

F. Bachelor's degree (4-year)

G. Master's degree

H. Doctoral degree

I. Professional degree (JD, MD)

J. Prefer not to say

6. What is your marital status?

A. Married

B. Widowed

C. Divorced

D. Separated

- E. Single
- F. Prefer not to say

7. What is your employment status?

- A. Full-time
- B. Part-time
- C. Contract or temporary
- D. Retired
- E. Unemployed
- F. Unable to work
- G. Prefer not to say

8. "What is your annual household income?"

- A. \$0-\$29,999
- B. \$30,000-\$59,999
- C. \$60,000-\$89,999
- D. \$90,000-\$119,999
- E. \$120,000+
- F. Prefer not to say

11. What is the primary language spoken in your home?

- A. English
- B. Spanish
- C. French
- D. Italian
- E. Portuguese
- F. Mandarin
- G. Arabic
- H. Urdu
- I. Other
- J. Prefer not to answer

13. Have you experienced COVID-19?

- 1. Yes.
- 2. No

14. Who do you know that has experienced COVID-19?

- A. Wife
- B. Husband
- C. Significant other (Partner)

D. Child

E. Family member

F. Friend

G. Other

H. Noone That I know

I. Prefer not to answer

15. Did you experience any mental health treatment during COVID-19 pandemic?

1. Yes

2. No

3. Prefer not to answer

13. Do you feel you would have received better mental health treatment if you were a different race or ethnicity during COVID-19 pandemic?

1. Yes

2. No

3. Prefer not to answer

14. Do you feel that you would have received better mental health care if you were a different gender during the COVID-19 pandemic?

1. Yes

2. No

3. Prefer not to answer

## Appendix B: Dass 21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree or a good part of time

3 Applied to me very much or most of the time

---

1 (s) I found it hard to wind down 0 1 2 3

2 (a) I was aware of dryness of my mouth 0 1 2 3

3 (d) I couldn't seem to experience any positive feeling at all 0 1 2 3

4 (a) I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion) 0 1 2 3

5 (d) I found it difficult to work up the initiative to do things 0 1 2 3

6 (s) I tended to over-react to situations 0 1 2 3

7 (a) I experienced trembling (e.g. in the hands) 0 1 2 3

8 (s) I felt that I was using a lot of nervous energy 0 1 2 3

9 (a) I was worried about situations in which I might panic and make a fool of myself 0 1  
2 3

10 (d) I felt that I had nothing to look forward to 0 1 2 3

11 (s) I found myself getting agitated 0 1 2 3

12 (s) I found it difficult to relax 0 1 2 3

13 (d) I felt downhearted and blue 0 1 2 3

14 (s) I was intolerant of anything that kept me from getting on with what I was doing 0 1  
2 3

15 (a) I felt I was close to panic 0 1 2 3

16 (d) I was unable to become enthusiastic about anything 0 1 2 3

17 (d) I felt I wasn't worth much as a person 0 1 2 3

18 (s) I felt that I was rather touchy 0 1 2 3

19 (a) I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat) 0 1 2 3

20 (a) I felt scared without any good reason 0 1 2 3

21 (d) I felt that life was meaningless 0 1 2 3

### Appendix C: Coronavirus Impact Scale

Rate how much the Coronavirus pandemic has changed your life in each of the following ways.

#### 1. Routines:

0. No change.

1. Mild. Change in only one area (e.g. work, education, social life, hobbies, religious activities). 2. Moderate. Change in two areas (e.g. work, education, social life, hobbies, religious activities). 3. Severe. Change in three or more areas (e.g. work, education, social life, hobbies, religious activities).

#### 2. Family Income/Employment:

0. No change.

1. Mild. Small change; able to meet all needs and pay bills.

2. Moderate. Having to make cuts but able to meet basic needs and pay bills.

3. Severe. Unable to meet basic needs and/or pay bills.

3. Food Access:

0. No change.

1. Mild. Enough food but difficulty getting to stores and/or finding needed items.

2. Moderate. Occasionally without enough food and/or good quality (e.g., healthy) foods.

3. Severe. Frequently without enough food and/or good quality (e.g., healthy) foods.

4. Medical health care access:

0. No change.

1. Mild. Appointments moved to telehealth.

2. Moderate. Delays or cancellations in appointments and/or delays in getting prescriptions; changes have minimal impact on health.

3. Severe. Unable to access needed care resulting in moderate to severe impact on health.

5. Mental health treatment access:

0. No change.

1. Mild. Appointments moved to telehealth.

2. Moderate. Delays or cancellations in appointments and/or delays in getting prescriptions; changes have minimal impact.

3. Severe. Unable to access needed care resulting in severe risk and/or significant impact.

6. Access to extended family and non-family social supports:

0. No change.

1. Mild. Continued visits with social distancing and/or regular phone calls and/or tele video or social media contacts.

2. Moderate. Loss of in person and remote contact with a few people, but not all supports.

3. Severe. Loss of in person and remote contact with all supports.

7. Experiences of stress related to coronavirus pandemic:

0. None.

1. Mild. Occasional worries and/or minor stress-related symptoms (e.g., feel a little anxious, sad, and/or angry; mild/rare trouble sleeping).

2. Moderate. Frequent worries and/or moderate stress-related symptoms (e.g., feel moderately anxious, sad, and/or angry; moderate/occasional trouble sleeping).

3. Severe. Persistent worries and/or severe stress-related symptoms (e.g., feel extremely anxious, sad, and/or angry; severe/frequent trouble sleeping).

8. Stress and discord in the family:

0. None.

1. Mild. Family members occasionally short-tempered with one another; no physical violence.

2. Moderate. Family members frequently short-tempered with one another; and/or children in the home getting in physical fights with one another.

3. Severe. Family members frequently short-tempered with one another and adults in the home throwing things at one another, and/or knocking over furniture, and/or hitting and/or harming one another.

9. Personal diagnosis of coronavirus.

0. None.

1. Mild. Symptoms effectively managed at home.
2. Moderate. Symptoms severe and required brief hospitalization.
3. Severe. Symptoms severe and required ventilation.

10. Number of immediate family members diagnosed with coronavirus: \_\_\_\_ Rate the symptoms of the person who was most sick:

0. None.
1. Mild. Symptoms effectively managed at home.
2. Moderate. Symptoms severe and required brief hospitalization.
3. Severe. Symptoms severe and required ventilation.
4. Immediate family member died from coronavirus.

11. Number of extended family member(s) and/or close friends diagnosed with coronavirus: \_\_\_\_ Rate the symptoms of the person who was most sick:

0. None.
1. Mild. Symptoms effectively managed at home.
2. Moderate. Symptoms severe and required brief hospitalization.
3. Severe. Symptoms severe and required ventilation.
4. Extended family member and/or close friend died of coronavirus.

## Appendix D: Barriers to Mental Health Services Scale Revised

Listed below are potential reasons why people do not seek out mental health services (e.g. counseling, psychotherapy). Please read each one carefully and indicate the extent to which you agree or disagree that the following barriers affect YOUR use of mental health services. Please try to pick an answer for each item, even if you are unsure.

1 Strongly Disagree

2 Disagree

3 Agree

4 Strongly Agree

1. A psychotherapist (counselor) would not understand me or my problems.

2. Psychotherapists(counselors) would not find working with someone my age worthwhile.

3. Feelings of sadness are typical for people my age.

4. I would not tell my physician if I was feeling down or depressed.

5. I would not even know how to begin to look for a psychotherapist (counselor).

6. Normal people do not go to psychotherapy (counseling).

7. Psychotherapy (counseling) is for people with severe mental health problems.

8. I would feel embarrassed or ashamed to see a psychotherapist (counselor).

9. I do not feel confident I could select a psychotherapist (counselor) who is right for me.
10. My physician does not have time to address mental health concerns.
11. A person's problems are his or her own business, not anybody else's.
12. It is difficult for me to find transportation to the psychotherapist (counselor).
13. A psychotherapist (counselor) is not qualified to help me with my problems.
14. I am afraid of what people would think of me if I went to a psychotherapist  
(counselor).
15. I have always solved my own problems.
16. I am not sure if psychotherapy (counseling) really works or is effective.
17. I am concerned that I would not be comfortable with a psychotherapist (counselor).
18. A lot of people feel sad and down.
19. Seeing a psychotherapist (counselor) is a sign of weakness.
20. It would be too difficult to get transportation for weekly appointments.
21. A psychotherapist (counselor) cannot understand the problems of someone my age.
22. Psychotherapy (counseling) is too expensive.
23. I cannot find a psychotherapist (counselor) who works with someone my age.
24. It is normal to feel more depression as we age.

25. Psychotherapists(counselors) have not been trained to work with people my age.
26. I am concerned that the information I share with a psychotherapist (counselor) will not be kept private.
27. It would be normal for me to sad or down given the circumstances of my life.
- 
28. I do not know what to look for in a psychotherapist (counselor).
29. People my age cannot benefit from psychotherapy (counseling).
30. I am uncomfortable with personal questions.
31. I cannot afford psychotherapy (counseling).
32. I do not know anyone who has benefited from psychotherapy (counseling).
33. I do not know the reasons people go to psychotherapy (counseling).
34. I would not know how to find a psychotherapist (counselor).
35. I do not drive.
36. People my age cannot change.
37. Psychotherapists' (counselors') time is better spent working with younger people.
38. Psychotherapists(counselors) would think working with someone my age is a waste of time.
39. I need to solve my own problems.
40. My insurance does not cover mental health care.
41. Public transportation is not available or too burdensome.
42. It would be difficult for me to ask my physician to refer me to a psychotherapist (counselor).

43. I cannot afford transportation to a psychotherapist's(counselor's) office.

44. It is hard for me to admit that I need professional help.

Scoring of the BMHSS-R 44-item version Scoring Instructions: To obtain a score on any subscale or a Total score, add all items contained in that scale.

Help Seeking (4 items): 11, 15, 39, 44 Stigma (5 items): 6, 7, 8, 14, 19 Knowledge and Fear of Psychotherapy (5 items): 17, 26, 30, 32, 33 Belief about Inability to Find a Psychotherapist (5 items): 5, 9, 23, 28, 34 Belief that Depressive Symptoms are Normal (4 items): 3, 18, 24, 27 Insurance/Payment Concerns (3 items): 22, 31, 40 Ageism (5 items): 2, 21, 36, 37, 38 Concerns about Psychotherapist's Qualifications (5 items): 1, 13, 16, 25, 29 Physician Referral (3 items): 4, 10, 42 Transportation Concerns (5 items): 12, 20, 35, 41, 43 -----  
----- Intrinsic Barriers: 3, 5, 6, 7, 8, 9, 11, 14, 15, 17, 18, 19, 23, 24, 26, 27, 28, 30, 32, 33, 34, 39, 44 Extrinsic Barriers: 1, 2, 4, 10, 12, 13, 16, 20, 21, 22, 25, 29, 31, 35, 36, 37, 38, 40, 41, 42, 43 Total Score: 1 - 44 -----

----- The primary citation for this revised measure (BMHSS-R) is as follows: Pepin, R., Segal, D. L., Klebe, K. J., Coolidge, F. L., Krakowiak, K. M., & Bartels, S. J. (2015). The Barriers to Mental Health Services Scale Revised: Psychometric analysis among older adults. *Mental Health & Prevention*, 3, 178-184.