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Self-Concealment, Perceived Discrimination, and African American Treatment Choices for Major Depression

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Abstract

African Americans have a higher proclivity to depression than other ethnic groups in the United States and also have a greater propensity to avoid seeking professional mental health treatment. The available research has shown that racial and cultural barriers such as perceived discrimination and self-concealment are the primary factors that negatively affect African Americans' attitudes toward mental health itself and mental health treatment. Perceived discrimination and self-concealment may also negatively affect whether African Americans seek help for depression and from whom, but further investigation was needed. The quantitative survey study provided answers to which factors influence whether and where African Americans seek help for major depression. A total of 147 participants were recruited through word of mouth, local churches, community organizations, and virtual venues such as electronic mail and social media. Multivariate analysis of variance revealed the mean scores of African Americans' use of natural supports and their use of outpatient treatment (dependent variables) were not equal across all levels of their self-concealment, perceived discrimination, and depressive symptoms (independent variables). Multivariate analysis of covariance revealed that the mean scores remained the same when controlling for gender, income, education, and relationship status (covariates). The results suggest that the latter factors influence African Americans' decisions on where to seek help for depression regardless of their gender and socioeconomic status. Increasing the propensity of African Americans to seek professional help for depression should improve the mental health of the population as a whole and reduce the incidents of serious mental illness of those who are treated.

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Dedication

I dedicate this study to those who struggle with major depression and those who experience racism, discrimination, and fear of using their voices. May this study inspire them to use their voices to strengthen their wellbeing and the wellbeing of others in similar situations.

Acknowledgments

I first want to thank my Lord and Savior, Jesus Christ, for His abounding grace and my ability to complete this project. Without Him, I would have lacked the courage to take on such a life-changing task. Lord, your grace abounds!

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To mom, Shirley, thank you for teaching me to work for what I want and to press through life's obstacles and setbacks. You exemplify the "strong black woman" to me and all who know you. I hope this achievement makes you proud of me.

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To all those who encouraged me along the way with kind words, knowledge, prayers, and constructive feedback, thank you for your investment in my betterment.

I hope this study sparks conversations, but, more importantly, I hope it ignites positive change.

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Chapter 1: Introduction to the Study

Introduction

Major depressive disorder (MDD) is the most prevalent mental disorder in the African American community (Bailey, Patel, Barker, Ali, & Jabeen, 2011; Ward & Brown, 2015; Ward, E., Wiltshire, J. C., Detry, M. A., & Brown, R. L., 2013). MDD in this group is significant because African Americans typically do not seek professional mental health treatment for depression or other psychological disorders (Bailey et al., 2011; Hunt, Caldwell, & Assari, 2015; Ward et al., 2013). MDD incapacitates individuals worldwide, but in the United States, African Americans suffer from depression longer and more frequently than some other ethnic groups (Bailey et al., 2011; Hays, 2015; Holden et al., 2012; Hunt et al., 2015; Meyers, Groh, & Binienda, 2014; Ward & Brown, 2015; Ward et al., 2013). Due to African Americans' underuse of professional mental health treatment and the prevalence of depression within their community, it is important to understand barriers that may be affecting their decisions not to seek appropriate mental health services for MDD.

Identifying potential barriers to African Americans' use of mental health services may be a further step toward solving the problem of underuse of mental health treatment in the United States. The ratio of African Americans in the United States to other ethnic groups is 3:22, but the ratio of African Americans who need mental health care compared to other racial groups is 3:5 (Davis, 2005; U.S. Census Bureau, 2018). The disproportionate mental health needs within the African American community are thought to be related to attitudes and beliefs about mental health professionals, leading

African Americans to avoid seeking treatment from a therapist or counselor. Their attitudes and beliefs about mental health also leads to avoidance of those experts (Madusa, Anderson, & Edmonds, 2012; Ward et al., 2013).

The available literature about African American attitudes toward mental health and associated factors such as religiosity, stigma, culture, race, depression, self-concealment, and perceived discrimination suggests a negative relationship between their mental health help-seeking attitudes and their beliefs about the causes of poor mental health and those who suffer from psychological problems (Campbell & Long, 2014; Cheng, Kwan, & Sevig, 2013; Conner et al., 2010; Gaston, Earl, Nisanci, & Glomb, 2016; Hays & Gilreath, 2017; Lukachko, Myer, & Hankerson, 2015; Madusa et al., 2012; Ward et al., 2013). The available literature also did not address how the factors of self-concealment, perceived discrimination, and depressive symptoms may be related to African Americans' choice not to use outpatient treatment from a mental health professional such as a counselor, therapist, or psychiatrist.

Because African American mental health problems are often untreated (Bailey et al., 2011; Hunt et al., 2015; Ward et al., 2013), I conducted this study to learn whether self-concealment and perceived discrimination are related to African Americans seldom choosing to seek treatment for MDD, considering their underuse of mental health services and the prevalence of MDD in the population. The findings bring insight into reasons African Americans are reluctant to seek professional care for mental health needs as well as develop a foundation for learning the reasons for mental health inequality in the population. Primary care doctors might use the findings to reduce the likelihood of

misdiagnosing African Americans with a severe psychotic disorder such as schizophrenia when they seek treatment for somatic symptoms that may also indicate depression (see Bailey et al., 2011; Plowden, Adams, & Wiley, 2016). The findings may also create awareness and offer information to African Americans who perceive depression as a personal weakness rather than a condition they did not bring on themselves (see Campbell & Mowbray, 2016; Hankerson, Suite, & Bailey, 2015; Lukachko et al., 2015; Schmitt, Branscombe, Postmes, & García, 2014; Ward et al., 2013).

In Chapter 1, I present the prevalence of depression and the underuse of mental health services in the African American community, including preliminary information on the relationships among self-concealment, perceived discrimination, and depressive symptoms of African Americans. I further explore how these factors may relate to African Americans' decisions to seek treatment for MDD. I also present the background, problem statement, research questions and hypotheses, conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance.

Background

African Americans who do not seek outpatient mental health treatment for MDD pose a significant mental health concern, as depression is the primary mental health disorder in the culture (Ward & Brown, 2015; Ward et al., 2013). MDD is debilitating, as it impairs overall functioning. The reason is not known, but depression is a greater problem among African Americans than in other racial groups in the United States (Meyers et al., 2014; Ward & Brown, 2015; Ward et al., 2013; Woods-Giscombé, Robinson, Carthon, Devane-Johnson, & Corbie-Smith, 2016). African Americans also

experience depression longer than other racial groups. As they are less likely to seek treatment for the disorder, the condition is prolonged (Bailey et al., 2011; Davis, 2005; U.S. Census Bureau, 2018; Ward & Brown, 2015; Ward et al., 2013). Although African Americans comprise about 20% of Americans with a mental disorder, they comprise only 12% of the U.S. population (see Davis, 2005; U.S. Census Bureau, 2018). That skewed mental health status may relate to their inadequate treatment for MDD that is likely to be a result of their underuse of outpatient mental health treatment (Villatoro & Aneshensel, 2014; Ward & Brown, 2015; Ward et al., 2013).

African Americans' underuse of outpatient mental health treatment by their reluctance to seek help from a qualified mental health professional such as a therapist or counselor is likely related to their skepticism about mental health problems and its treatment in general (Madusa et al., 2012; Watson & Hunter, 2015). The available literature has revealed that religion, stigma, culture, race, depression, self-concealment, and perceived discrimination have all an inverse relationship to African Americans' mental health help-seeking attitudes and treatment-seeking behaviors (Campbell & Long, 2014; Cheng et al., 2013; Conner et al., 2010; Gaston et al., 2016; Hays & Gilreath, 2017; Lukachko et al., 2015; Madusa et al., 2012). Historical factors such as racial discrimination and events such as the "Tuskegee Study of Untreated Syphilis in the Negro Male," begun in 1932, de facto and de jure segregation and the Jim Crow era may have diminished African Americans' trust in healthcare in the United States (Feagin & Bennefield, 2014; Hurd, Varner, Caldwell, & Zimmerman, 2014; Schmitt et al., 2014). The paucity of available literature on the effects of self-concealment, perceived

discrimination, and depressive symptoms related to African Americans' reluctance to use outpatient mental health treatment for MDD prompted the need for this study.

Decoding the African American Ethnicity

The complexity of MDD and the paucity of African Americans seeking outpatient treatment for mental health problems should be evaluated in the context of their ethnic identity. In some studies, researchers have misrepresented African Americans as a homogenous group, a process that adulterates any research of African Americans, as the group is as diverse as any other culture (Woodward, Chatters, Taylor, & Taylor, 2015). African Americans, however, are comprised of various ethnic groups, which include those of African descent who may have been born in the United States, the Caribbean, Africa, Central America, Europe, and other parts of the world as a result of slavery and voluntary immigration (Locke & Bailey, 2013). The disbursement of the African people warranted the identification of the population within the category African American, that was the basis for this study.

The geographical history of those of African descent is connected to their ethnic identification. Locke and Bailey (2013) described possible ethnic identifications that some of them may hold was that African Americans born outside of the United States who now live in the states may bond strongly with their country of origin and subscribe to the ethnic identity of their homeland. A person born in Nigeria, for example, who lives in America may identify as Nigerian American rather than African American. Consideration of Nigerian identification is noteworthy, as the person might view depression and its treatment like others in Nigeria would view it. Locke and Bailey

provided a contrasting view that those of African descent who live in the United States, regardless of where they were born, may identify with African American ethnic identity or as African American. Locke and Bailey emphasized that personal ethnic identification should take precedence in the studies of people of African descent. The participants in this study, therefore, were those of African descent living in the United States who identified as African American.

Religion in the African American Community

The diversity of African Americans also relates to their religious beliefs and practices and how they handle mental health problems. Lukachko et al. (2015) found that African Americans with low mental health services use have high religiosity associated with their relationship with the Black Church, a group of Protestant churches that many African Americans attend and have depended upon for education, support, and resources since slavery (Avent, Cashwell, & Brown-Jeffrey, 2015; Hardy, 2014; Hays, 2015; Lincoln & Mamiya, 1990; Lukachko et al., 2015).

A 1990 longitudinal study by Lincoln and Mamiya revealed that religiosity and the Black Church are associated positively among African Americans. Lincoln and Mamiya also found that depressed African Americans often seek support from their churches when distressed. Those of African descent who identify with their country of origin, on the other hand, may not solicit help from the Black Church or even recognize its function in the African American community. In the Black Church, however, many African Americans seek support from their church or pastors as their primary source of help when they have problems or emotional unrest (Avent et al., 2015; Crosby & Varela,

2014; Hankerson, Watson, Lukachko, Fullilove, & Weissman, 2013; Lukachko et al., 2015; Ward et al., 2013). African Americans who tend to be highly religious and seek help from their pastors or the Black Church may attribute psychological problems or emotional disturbances to spiritual causes and reason that the disturbances require spiritual interventions such as prayer (Lukachko et al., 2015; Woods-Giscombé, 2010). The belief that psychological problems are spiritual problems may persuade them not to seek a mental health professional for MDD that is adequate treatment.

The Beliefs, Stigma, and Perceived Discrimination Connection

African Americans' other beliefs may also relate to their mental health, as their history of suffering from social injustice has shaped many cultural beliefs (Holden et al., 2012; Cokley et al., 2017; Cokley, McClain, Enciso, & McClain, 2013; Hurd et al., 2014; McClain et al., 2016; Peteet, Brown, Lige, & Lanaway, 2015; Peteet, Montgomery, Weekes, 2015; Schmitt et al., 2014). Events such as *de jure* segregation, the Jim Crow era, lynchings, and the Tuskegee Experiment are examples of historical events that may affect their beliefs and cause them to anticipate racism and other social injustices (Feagin & Bennefield, 2014; Hurd et al., 2014; Osanloo, Boske, & Newcomb, 2016; Schmitt et al., 2014).

In the Tuskegee Experiment, potentially lifesaving penicillin was withheld from the treatment of incarcerated African American males in a 40-year syphilis experiment without their knowledge, and many died as a result (Feagin & Bennefield, 2014; Hurd et al., 2014; Schmitt et al., 2014). The United States Public Health Service and the Tuskegee Institute led the research study, telling African American sharecroppers from

Macon County, Alabama, that they were receiving free medical care for "bad blood," not syphilis, and not giving them the penicillin that was the best treatment for the disease (Centers for Disease Control and Prevention [CDC], 2017; Feagin & Bennefield, 2014). A result of this treatment or lack thereof is that some African Americans may mistrust medical professionals and may anticipate further racist treatment from them (Feagin & Bennefield, 2014). As a result, many may decide to live with their depression and other psychological symptoms or hope they resolve on their own (Hankerson et al., 2015).

African Americans' mistrust of medical professionals and their possible anticipation of racist treatment suggest they fear discrimination if they look to them for help. A Campbell and Long (2014) study supported the belief that some African Americans are hesitant to seek help from American health care out of fear of mistreatment. Some in the study even reported they believed doctors provided better treatment to other ethnic groups than they did to them (Campbell & Long, 2014). African Americans' belief about medical professionals may create a barrier to seeking outpatient treatment for depression because of that perceived discrimination (Schmitt & Branscombe, 2002; Schmitt et al., 2014). Perceived discrimination also includes a view of one's advantaged or disadvantaged classification as a harmful or protective factor within that social context (Schmitt & Branscombe, 2002; Schmitt et al., 2014).

In a medical office, African Americans may view themselves as disadvantaged and medical staff as advantaged and may perceive being a patient as threatening, increasing the perception that doctors or others will not prescribe the correct treatment. That fear of discrimination puts them at a higher risk of psychological problems, such as

prolonged depression, compared to other cultures (Bailey et al., 2011; Cheng et al., 2013; Hays, 2015; Hunt et al., 2015; Hurd et al., 2014; Ward et al., 2013).

The available scholarly literature showed that fear of discrimination creates a complex barrier for African Americans who need help for depression and other mental health symptoms that affect multiple areas of their lives (Campbell & Long, 2014; Hurd et al., 2014; Molina & James, 2016; Schmitt et al., 2014). Some African Americans might even believe psychological professionals are seeking information that will expose their vulnerabilities and may target them for further discrimination (Campbell & Long, 2014). Others may prioritize going to work over seeking mental health care, deeming it inconvenient and costly, possibly related to their economic struggles (Campbell & Long, 2014). African Americans' fear of being vulnerable socially and economically may be one reason they believe that mental illness is stigmatizing, a fear that may cause them to neglect their mental health when they need treatment (Campbell & Mowbray, 2016).

The feeling of being stigmatized because of race may impose the belief that a certain characteristic discredits one's identity (Goffman, 1963; Campbell & Mowbray, 2016). This may be the most powerful barrier to African Americans seeking mental health treatment, as some hold to the notion that a depressed person is weak or mentally ill (see Campbell & Mowbray, 2016; Ward et al., 2013). African Americans who believe that depression reveals a personal weakness may use other ways to cope with mental health problems, preferring to talk to a pastor, pray, or hide their problems (Campbell & Mowbray, 2016; Hankerson et al., 2015; Lukachko et al., 2015; Schmitt et al., 2014; Ward et al., 2013). African Americans who hide their problems are demonstrating self-

concealment, a risk factor for continuing depression and other psychological complications (Larson & Chastain, 1990; Larson, Chastain, Hoyt, & Ayzenberg, 2015).

Self-Concealment

Self-concealment is the practice of intentionally suppressing information a person perceives as humiliating or harmful about himself or herself for self-preservation (Larson & Chastain, 1990). African Americans may try to avoid racism, discrimination, and stigmatization from others by hiding the psychological problems they may perceive as harmful to themselves through self-concealment, a situation that merits investigation. Understanding the significance of self-concealment among African Americans is important to medical professionals, as self-concealment is a risk factor for depression (Larson & Chastain, 1990; Larson et al., 2015; Ward et al., 2013). Examining whether African Americans conceal their psychological needs in an attempt to avoid ridicule and harassment from others may assist in understanding why many African Americans neglect depressive symptoms when they arise. Self-concealment may even be a consequence of African Americans believing that a mental health problem is stigmatizing. Conceivably, African Americans who associate seeking treatment as a stigma or personal flaw may practice self-concealment of their emotional problems, fearing discrimination from advantaged groups such as mental health service providers.

The need to learn whether self-concealment is a possible cause of depression is critical because of the high rate of suicide among African Americans (Lincoln, Taylor, Chatters, & Joe, 2012; Larson et al., 2015; Madusa et al., 2012; Ward et al., 2013). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American

Psychiatric Association [APA], 2013) identified one of the nine symptoms of MDD as "recurring thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide" (p. 161). Friedlander, Nazem, Fiske, Nadorff, and Smith (2012) studied suicidal behaviors, self-concealment, and depression in young African Americans and found that those with elevated levels of self-concealment are more likely to manifest suicidal behaviors. Friedlander et al. further found that older African Americans with elevated levels of self-concealment and suicidal behaviors are more likely to have symptoms of depression. With suicide rates having increased more than 50% among African Americans during the 20th century, it is reasonable to conclude that depression rates have also increased (Lincoln et al., 2012). The links among suicidality, depression, self-concealment, and the potential of the suicide rate continuing to rise in the African American community suggests the need to learn the potential barriers to African Americans seeking treatment for MDD.

Problem Statement

In the United States, depression in the African American community is significant, as 9.1% of African Americans are affected by the disorder, while only 6.9% of the total American population is affected at the same rate (Mental Health America, 2019; U.S. Census Bureau, 2018). African Americans also suffer from depression longer than other ethnic groups, and they are less likely than other populations to seek professional mental treatment due to racial and cultural barriers (Bailey et al., 2011; Siddique, Chung, Brown, & Miranda, 2012; Stewart, 2015). Barriers to their seeking

professional mental health treatment may likely relate to their experiences with racial prejudice and discrimination because they are African American (Chaney & Robertson, 2015; Feagin & Bennefield, 2014; Jee-Lyn García & Sharif, 2015; Moore et al., 2016; Paradies et al., 2015; Williams & Mohammed, 2013; Woodward et al., 2015). African Americans who perceive they are being discriminated against are at increased risk for depression, anxiety, and substance use (Cheng et al., 2013; Hurd et al., 2014).

It is unclear if African Americans who consider depression to be a personal weakness also perceive discrimination and avoid seeking professional mental health services, particularly outpatient counseling from a therapist or counselor (Campbell & Mowbray, 2016; Hankerson et al., 2015; Lukachko et al., 2015; Schmitt et al., 2014; Ward et al., 2013). African Americans may ask ministers, family members, or other natural supports for help when they are distressed and hide their depression from other relatives, friends, or acquaintances to avoid stigmatization and discrimination (Bailey et al., 2011; Campbell & Long, 2014; Chatters, Mattis, Woodward, Taylor, Neighbors, & Grayman, 2011; Jackson, 2013; Ward et al., 2013). Their underuse of treatment when they experience symptoms of depression may be a manifestation of their self-concealment and perceived discrimination that exacerbates their feelings and may result in the development of MDD. They additionally may perceive themselves as a disadvantaged group within the American healthcare systems. There is a need, then, to learn whether self-concealment and perceived discrimination influence African Americans' choice not to seek treatment for MDD and to learn the factors that influence them to seek help.

Purpose of the Study

The purpose of this quantitative study was to investigate whether the levels of the independent variables-self-concealment (SC), perceived discrimination (PD), and depressive symptoms (DEP)-influence African Americans' decisions to use natural supports (NS) or to use outpatient treatment (OT) (dependent variables) for MDD. I surveyed a group of African Americans who use NS such as a spiritual advisor or family member rather than seeking treatment from a professional counselor or psychologist. I examined the independent and dependent variables, controlling for gender, income, education, and relationship status. The relationships among SC, PD, and DEP, use of NS, and OT use are significant considering the negative correlation between PD and psychological distress in African Americans as well as a link between SC and depression (Larson & Chastain, 1990; Larson et al., 2015; Schmitt et al., 2014). The results add to the current literature about SC and PD among African Americans who use NS rather than outpatient professional treatment for depression and may provide greater understanding of certain aspects of the mental health inequalities of that specific population.

Research Questions and Hypotheses

I used a quantitative survey approach to answer the main research question: How do the factors of SC and PD influence whether and where African Americans seek help for major depression? I also examined the responses to two subquestions to answer the central research question sufficiently.

Research Question 1: Does the use of NS and outpatient OT mean scores (dependent variables) of African Americans vary by their levels of SC, PD, and DEP (independent variables), and, if so, which one distinguishes their NS and OT score most?

Null hypothesis: The mean scores of NS and OT are equal across all levels of SC, PD, and DEP.

Alternative hypothesis: The mean scores of NS or OT differ across at least one level of SC, PD, or DEP.

Research Question 2: Do the NS and OT mean scores of African Americans vary by their levels of SC, PD, and DEP, when controlling for the effects of gender, income, education, and relationship status?

Null hypothesis: The mean scores of NS and OT are equal across all the levels of SC, PD, and DEP, when controlling for gender, income, education, and relationship status.

Alternative hypothesis: The mean scores of NS or OT differ across at least one of the levels of SC, PD, or DEP, when controlling for gender, income, education, and relationship status.

Conceptual Framework

I used a conceptual framework to evaluate the relationship between the PD and SC constructs concerning MDD in African Americans following the Negulube, Mathipa, and Gumbo (2015) model as it is used in research:

- It is an argument describing the abstract phenomenon guiding the research study,

- It formulates concepts or constructs to provide an understanding, as opposed to an explanation of a phenomenon, and
- It proposes a frame of reference less developed than a theoretical framework.

From this perspective, the PD and SC constructs offered a conceptual framework that suggested African Americans demonstrate a unique attitudinal and behavioral phenomenon about their mental health. As stated, available research has shown a negative relationship between African Americans' help-seeking attitudes and their beliefs about mental health linked to their religiosity, stigma, culture, race, depression, SC, and PD (Campbell & Long, 2014; Cheng et al., 2013; Conner et al., 2010; Gaston et al., 2016; Hays & Gilreath, 2017; Lukachko et al., 2015; Madusa et al., 2012; Ward et al., 2013). The negative relationship among those factors may broaden the interpretation of African Americans' decisions about where they seek treatment for MDD.

African Americans may display PD and SC in any of the following six dimensions, both attitudinally and behaviorally:

1. The supposition that depressive symptoms are negative attributes one must keep secret from others (attitudinal-PD and SC).
2. The belief that depressive symptoms are in fact physical symptoms resulting in ignoring that these symptoms require mental health treatment and seeking only medical treatment (attitudinal SC).
3. The assessment that the implied hierarchal relationship between a mental health professional (advantaged) and patient (disadvantaged) is harmful (attitudinal PD).

4. The choice to seek help from NS when depressed (behavioral SC).

5. The avoidance of treatment from a mental health professional (behavioral SC and PD).

6. Having experienced poor psychological wellbeing: lower self-esteem, poor life satisfaction, and greater depression, anxiety, and psychological distress (Larson & Chastain, 1990; Schmitt et al., 2014) as a result of untreated psychological distress (behavioral-SC/PD)

The following sections provide further explanation of the relevance of these concepts to the study.

Self-Concealment

Larson and Chastain (1990) developed the SC construct by building on previous studies of the concepts of self-disclosure and behavior inhibition developed by Jourard (1971) and Pennebaker (1985). Larson and Chastain conducted a comprehensive study distinguishing self-disclosure and SC as two related but different processes. Self-disclosure requires a person to openly share with other people aspects and experiences regarding himself or herself. Jourard indicated that one who demonstrates self-disclosure exhibits his or her "transparent self," and as a result, has a healthy personality. In contrast, Jourard indicated that one who demonstrates nondisclosure alienates himself or herself, resulting in a "neurotic" personality or sickening role as he or she attempts to conceal his or her transparent or true self (p. 30). African Americans who conceal sensitive information about themselves that they perceive as weak and detrimental if it were known to others may develop depression from the acts of hiding their true selves.

Additionally, Larson and Chastain noted that in 1985, Pennebaker defined behavior inhibitions as actions such as lying or keeping secrets that may cause serious physiological changes that may lead to chronic disease. Pennebaker also showed that "the act of not discussing or [revealing an] event with another may be more damaging than having experienced the event per se and that the act of discussing traumatic events may improve physiological functioning" (p. 82). Jourard, Pennebaker, and Larson et al. also suggested that the mental effort required to conceal what one may perceive as negative information might, of itself, harm a person's physical and psychological well-being and lead to depression.

Knowing that MDD is the leading mental disorder in the African American community and that African Americans are unlikely to seek appropriate help for mental health problems suggests the need for learning whether SC contributes to African Americans not seeking OT for DEP. African Americans who conceal their depression may do so as they perceive that they will experience social and cultural difficulties within their culture and American society, and their nondisclosure could relate to these perceptions.

Using the PD and SC constructs as a conceptual framework assisted in providing an understanding of how perceiving social difficulties may inhibit African Americans from seeking professional treatment for depression. It further guided my research into how SC may contribute to long-term mental health problems, as the reason DEP may be prevalent among African Americans is they may wait too long to get the right help. As I describe in greater detail in Chapter 2, many African Americans have a negative attitude

toward mental health that may result in their not choosing professional treatment and using the NS of their culture. The examination of SC in African Americans is appropriate, as Larson and Chastain (1990) and Larson et al. (2015) found that elevated levels of SC increases one's chances of developing DEP, anxiety, or other psychological problems. African Americans having negative attitudes toward mental health problems suggests that they may be likely to conceal their depressive symptoms as well as their need to treat these symptoms. Their negative attitudes toward mental health and mental health treatment are likely to be a result of their PD against those of their culture (Hurd et al., 2014; Schmitt et al., 2014).

Perceived Discrimination

PD can predict not only DEP in African Americans, it is also a potential barrier to their seeking professional mental health treatment (Cheng et al., 2013; Hurd et al., 2014). The history of African Americans experiencing racism in the United States since slavery and current social injustices such as police violence toward them illustrate the reason many African Americans may perceive discrimination in other social contexts, such as an outpatient clinic or another medical facility (Brondolo et al., 2005; Chaney & Robertson, 2015; Jee-Lyn García & Sharif, 2015; Moore et al., 2016; Paradies et al., 2015; Williams & Mohammed, 2013). They may perceive that when they interact with non-African American professionals, even those in mental health, that they are perceived as an inferior group subject to maltreatment from a superior group. Bailey et al. (2011) posited that some African Americans assume that a mental health professional will discriminate against them if they seek their treatment. It was important to consider in this study the

relevance of PD and SC constructs, as African Americans may have the predisposition to postpone mental health treatment that evidence shows contributes to DEP and poor psychological health (Gaston et al., 2016; Ward et al., 2013).

Nature of the Study

I used a quantitative survey design that began with recruiting and collecting data from African Americans in churches and community organizations through e-mail and social media such as Facebook, Instagram, Google+, and others. I used a three-factor multivariate analysis of variance (MANOVA) to address Research Question 1 to test the null hypothesis that the mean scores of African Americans' use of NS and their use of OT were equal across all levels of the independent variables of SC, PD, and DEP. SC, PD, and DEP are independent variables that have two levels: low and high. NS and OT are the dependent variables I measured using the Preferred Coping Scale (see Ward et al., 2013; Ward & Heidrich, 2009) and converted to dichotomous variables for the MANOVA. The MANOVA was appropriate for the analysis as it reduced the chances of Type I errors: incorrect rejection of the null hypotheses considering the inclusion of multiple independent and dependent variables (Field, 2013). I used a three-factor multivariate analysis of covariance (MANCOVA) to address Research Question 2 to control for covariates and to test the null hypothesis that the mean scores of African Americans' NS and OT are equal across all the levels of SC, PD, and DEP, when controlling for gender, income, education, and relationship status (covariates). A detailed description of the data analysis plan and assumptions are discussed in Chapter 3.

Definitions of Terms

African American: For this study, it is the group of heterogeneous persons of African descent who live in the United States, experienced American socialization, and identify as African American (Locke & Bailey, 2013; Sanchez & Awad, 2016; Woodward et al., 2015).

MDD: MDD is the presence of at least 5 of 9 symptoms such as a depressed mood most days, loss of pleasure in doing normal activities, significant changes in weight or appetite, sleep disturbance like insomnia, restlessness or moving observably slowly, suffering from fatigue, guilt or feelings of worthlessness, trouble concentrating, and suicidal thoughts or plans (APA, 2013).

NS: NS are family members, friends, clergy, or other persons or professionals not specifically trained in a mental health specialty such as a primary care doctor (see Bailey et al., 2011; Lincoln & Mamiya, 1990). Some persons rely on people such as those rather than professionals trained in counselling.

OT: OT includes visiting a mental health provider for complaints about psychological symptoms such as those described under MDD. A mental health provider is a licensed professional counselor, clinical social worker, marriage and family therapist, mental health counselor, psychologist or psychiatrist, nurse practitioner in psychiatry, and university counselor.

PD: PD describes a person's internal assessment of social situations in which he or she classifies himself or herself and others as belonging to one or two groups--privileged or underprivileged. The person rationalizes that those in the underprivileged or

disadvantaged group are at risk or harm from the privileged or advantaged group, whom they sense are protected because of their privileged status in that context (Schmitt & Branscombe, 2002; Schmitt et al., 2014).

SC: SC is the practice of keeping secret one's personal information perceived to be embarrassing or negative (Larson & Chastain, 1990; Larson et al., 2015).

Assumptions

I assumed that participants' responses on survey items accurately represented their levels of SC, PD, depressive symptoms, use of NS, and use of OT. I also assumed that participants understood the language of the survey items written in standard English.

Scope and Delimitations

The results of the present study are not generalizable, given its survey design, but they do provide preliminary evidence that can be used in future studies. The participants all identified themselves as African American. Woodward et al. (2015) indicated that African Americans are a heterogeneous group with African ancestry and that not all of African ancestry may identify themselves as African American. Individuals with African ancestry or who possess certain skin pigmentation or facial features may be classified as African American by researchers or medical professionals, though those people may not identify with that ethnic group (Locke & Bailey, 2013; Woodward et al., 2015). To avoid the potential misclassification of participants, I included only respondents who identified themselves as African American and excluded those who initially stated they met the research criteria but acknowledged belonging to another ethnic group in the final sample.

Limitations

One limitation of the study was that it was a nonexperimental research design that was not generalizable and cannot determine a cause-and-effect relationship. The findings did, however, reveal the differences in the levels of SC, PD, and depressive symptoms as they related to participants' use of NS and their use of OT. The second limitation was that African Americans may inaccurately report their symptoms, as research has shown that African Americans tend to identify their depressive symptoms as somatic complaints rather than psychological symptoms (Bailey et al., 2011). A third limitation was that I am an African American who has witnessed and experienced discrimination in the United States. I also have family members who lived during the Civil Rights era whose sharing their experiences may have caused personal biases. By recognizing my potential biases early in the research, I remained aware of how they might affect this study and sought to control for them.

Significance

The study should be significant even with its potential limitations and biases. African Americans' limited use of available OT and mental health services is both well-documented and an important concern because of racial mental health disparities in the United States (Bailey et al., 2011; Hays, 2015; Hunt et al., 2015; Madusa et al., 2012; Ward et al., 2013). Because of its importance, I examined the differences in the levels of SC, PD, and depressive symptoms among African Americans as they related to their choices to use NS or outpatient professional treatment. Understanding factors that may contribute to DEP could be a step toward reducing mental health inequality in the United

States, may assist in reducing untreated DEP, and might increase the overall well-being of African Americans through the following:

1. Improving primary care physicians and mental health professionals' capacity to accurately screen, assess, and diagnose DEP in African Americans,
2. Bringing an awareness to African Americans of the prevalence of DEP in their culture and suggesting appropriate treatment for the disorder,
3. Encouraging African Americans to seek OT when symptoms arise,
4. Providing a foundation for researchers to further examine SC and PD regarding other mental health issues experienced by African Americans, and
5. Offering a basis for community-based organizations such as clinics, churches, and civic clubs to educate African American members and affiliates about effective mental health treatment options and strategies and the mental health risk factors of the population.

Summary

Chapter 1 provided preliminary information to guide the examination of the differences in African Americans' levels of SC, PD, and depressive symptoms, and how these differences may relate to their decisions to use NS or seek OT for MDD. Because current research addresses African Americans' attitudes toward treatment and mental health but not how factors such as SC and perceived discriminate relate to their use of outpatient services, the study and its results should add a needed component to the field of mental health.

In Chapter 2, I provide an extensive literature review on DEP in the African American community and the effects of SC and PD on their mental health. Chapter 3 includes the methodology used to assess the various levels of SC, PD, depressive symptoms, the use of NS, and OT. In Chapter 4, I describe the data collection, analysis, and study results, and I conclude Chapter 5 with a discussion and interpretation of the data, the study limitations, and how the results may promote social change.

Chapter 2: Literature Review

Introduction

To build a foundation for this study, I reviewed the available literature about the underuse of OT and prominence of major DEP in the African American community. The chapter includes an exploration of issues that influence African Americans to decide whether to seek treatment for major DEP that may relate to SC and PD or to seek religious support for the problem. SC is consciously hiding one's personal information such as mental health status or emotional distress they perceive as negative or embarrassing from others (Larson & Chastain, 1990; Larson et al., 2015). PD, on the other hand, relates to one's perception that advantaged groups are prejudiced and exert power over disadvantaged groups (Schmitt & Branscombe, 2002; Schmitt et al., 2014). It is also the interpretation of whether authority and bias are harmful or protective (Schmitt & Branscombe, 2002; Schmitt et al., 2014). Presenting the factors that influence African Americans to seek help for DEP expands the understanding of African Americans' mental health problems and the reasons for their underuse of mental health services.

I used the PsycINFO, PsycARTICLES, SAGEJournals, Medline, and National Institute of Health databases along with the Google Scholar search engine to find literature for the review. I searched for articles published in the last 5 years but expanded the search to older literature that relates to the study. I located articles related to African Americans and mental health use using the terms *mental health, mental health utilization, mental health services, mental health treatment, outpatient treatment, professional treatment, health care, major depression, depression, psychological services African*

American, Black American, Black, minorities, and *African*. The preliminary searches revealed that religious coping, NS, and help-seeking are relevant to African Americans' mental health; therefore, I used the following additional terms to further my search: *religious coping, church, natural support, pastor, pastoral care, pastoral support, help-seeking, help-seeking attitudes,* and *treatment-seeking*.

The Term African American

Although African Americans are relatively heterogeneous (Locke & Bailey, 2013; Sanchez & Awad, 2016; Woodward et al., 2015), the use of broad terms such as Black or African American is prevalent in research as well as in the United States. Sellers, Smith, Shelton, Rowley, and Chavous (1998), in a classic, but dated study, provided a relevant distinction between the terms Black and African American. Black is an ambiguous term that does not describe all people of African descent, as that distinction is based on a person's perspective about skin pigment (Sellers et al., 1998, p. 19). A Latino Caribbean, for instance, who may have similar physical features to an American-born Black person, may be termed Black by a White or another Black person. Another perspective is that the label Black is exclusive to a group within the heterogeneous group (Sellers et al., 1998).

A Black person born in the United States, for example, may not view a Latino Caribbean as Black who is of African descent or has similar physical features. In contrast, the term African American implies a person of African descent who has experienced American socialization "within the context of American society" (Sellers et al., 1998, p. 19) that may have included experiences with racism and discrimination. Sellers et al.'s (1998) definition of the term African American was used in this study not only for

consistency but also to challenge the Black and White dichotomy in American society (Sanchez & Awad, 2016). For this study, an African American is one who identifies with the African American ethnic group, has ever lived in the United States for at least 6 months, and has African ancestry.

African Americans and DEP

Although DEP is the most prevalent mental disorder in the African American community, it is untreated for reasons unrelated to those of other ethnic groups (Ward et al., 2013). African Americans who do not seek OT from counselors or therapists for DEP may create a more serious mental health problem. Stigma related to their concern about being viewed by others as weak and the need to be strong are barriers to their seeking or receiving help for the condition (Bailey et al., 2011; Campbell & Mowbray, 2016; Nicolaidis et al., 2010; Woods-Giscombé, 2010; Woods-Giscombé et al., 2016). Although they have a higher incidence of DEP, African Americans suffer from it longer and may more frequently require hospitalization because of their not seeking treatment when the condition manifests itself (Bailey et al., 2011; Hays, 2015; Hays & Gilreath, 2017; Ward et al., 2013). Those who live with DEP longer without treatment are also likely to develop an MDD, the fourth-largest disabling disorder in the world (Holden et al., 2012; Meyers et al., 2014).

MDD can inflict a person with a physical problem because of its deleterious effects on not only mood, sleep, self-esteem, finances, and functioning on the job, but because it may exacerbate the potential for committing suicide (APA, 2013; Bailey et al., 2011). The World Health Organization (2017) noted that DEP is the leading cause of

disability in the world and a large contributor to global disease, as it affects more than 300 million people globally. The tendency to avoid seeking OT for DEP among African Americans from a professional mental health counselor, compared with other ethnic groups, is likely a major contributor to African Americans' increased likelihood of hospitalization for mental health problems (Hankerson et al., 2013; Lincoln et al., 2012; Molock, Matlin, Barksdale, Puri, & Lyles, 2008). Although African Americans are 12% of the total U.S. population, they comprise 20% of those with a mental disorder (Davis, 2005; U.S. Census Bureau, 2018). Examining the reasons for African Americans' underuse of OT for MDD is necessary to understand their disproportionate representation among mental health disorders in the United States.

Defining African American Ethnic Identity

Defining African American ethnic identity is an essential component of a study of African Americans. Assuming that a person is African American because of skin color, physical features, or ancestral ties to Africa can prevent fully understanding their culture and milieu. The broader African American culture consists of various ethnic groups that include people of African descent who may have been born in the United States, the Caribbean, Africa, Europe, or anywhere else in the world (Locke & Bailey, 2013). Despite where they were born, Sanchez and Awad (2016) noted that some in the United States consider people of African descent to be African American or Black because of their pigmentation; however, African Americans are more diversified than these few subjective labels suggest. In 2010, for example, over 1 million Black Caribbeans, such as Haitians, lived in the United States (Gaston et al., 2016; Sanchez & Awad, 2016).

Woodward et al. (2015) postulated that some people consider Black and Latino Caribbeans, for example, as African American in the United States, which can result in researchers and professionals labelling groups that are dissimilar except for skin color as African Americans and considering them a homogenous group. According to Locke and Bailey and Woodward et al., viewing African Americans as a homogeneous group is a flawed approach to research because of the effects of slavery and immigration on the people of African descent. Rather than viewing African Americans as homogeneous, researchers and professionals should correctly view African Americans as a heterogeneous ethnic group with both similarities and differences (Locke & Bailey, 2013).

Demystifying the African American ethnic identity to view their heterogeneity correctly requires an understanding of group differences regarding generational ties. Locke and Bailey (2013) suggested that African Americans born outside of the United States and now live in the United States might have stronger generational ties with their home country than their adopted country. Having strong generational ties means that the person may identify with the ethnic identity of their country of origin rather than their host (or new) country (Locke & Bailey, 2013). A person living in the United States who was born in Nigeria or who has Nigerian ancestry, for example, may identify as Nigerian rather than African American.

Those who identify with African American culture comprised the group in this study, as they may hold similar beliefs about their mental health as others in that distinct group. Sanchez and Awad (2016) examined whether within-group differences existed

regarding racial identity and PD between Black Caribbeans, Latino Caribbeans, and African Americans. They found that significant within-group differences did not exist and surmised that their findings were the result of the study participants being born and reared in the United States. Their findings supported the notion that those of African descent who have lived in the United States would have more similarities in their experiences of being discriminated against and racial perceptions as those who identify as African American. Sanchez and Awad also found that higher levels of DEP across Black Caribbeans, Latino Caribbeans, and Africans correlated with high levels of dissonance and attitudes regarding immersion racial identity.

The positive correlation between DEP, dissonance (conflict), and racial identity suggests that it is important to recognize the adverse mental health outcomes for people who identify as African American. Racial identity represents a person's cognition, perception, and investment in the cultural patterns of their racial group and reflects the degree to which people perceive situations as racist and the seriousness of how they rate these experiences (Sanchez & Awad, 2016). Dissonance relates to racial awareness through questioning and confusion, while immersion is the way one learns about their race and culture (Sanchez & Awad, 2016). It seems logical that those with a firmer African American identity through immersion into African American culture would identify with others in the same culture. In contrast, there is an alternative viewpoint with regard to Sanchez and Awad's findings. The participants in the study were "Americanized" by American socialization. It stands to reason that individuals from the Caribbean or other parts of the world that some people in the United States might

otherwise consider African Americans have different racial and ethnic experiences as well as generational ties. The alternative view is that professionals should ask those they may assume are African American what ethnic identity they identify with.

Religion and African Americans

Similar to the earlier point regarding the connection between generational ties and African American ethnic identity, religion is a significant generational factor in African American culture. Lincoln and Mamiya (1990) conducted a 10-year study interviewing over 1,800 clergy about the African American religious experience and reported that African Americans, as a culture, have participated in religious practices, including worship services, dating back to slavery (Lincoln & Mamiya, 1990). They highlighted that African Americans' religious practices and history focus on the importance of biblical principles as well as the belief in Jesus Christ as God in human form and his suffering, crucifixion, and resurrection (Lincoln & Mamiya, 1990). Ironically, African Americans as a culture learned about Jesus Christ or Christianity from their White American slave masters (Lincoln & Mamiya, 1990). They practiced public worship as their slave masters allowed, but others still worshipped as they or their ancestors worshipped in Africa (Lincoln & Mamiya, 1990). Since slavery, African Americans who believe in the incarnate Jesus Christ and His suffering manifest this belief through their faith and worship, especially those who find a parallel in the suffering and victory of Jesus in their own oppression (Lincoln & Mamiya, 1990). The belief that challenging experiences similar to the suffering of Jesus Christ some African Americans endure may reveal itself in how they view and respond to DEP (Lincoln & Mamiya, 1990). Some

African Americans believe that DEP and mental illness arise from a demonic influence such as evil spirits or Satan (Avent et al., 2015). African Americans with depressive symptoms who believe that Satan causes DEP may rely on religion to contend with a perceived Satanic influence, but others may find their own faith is inadequate and seek support from the Black Church.

The Development and Influence of the Black Church

Lincoln and Mamiya (1990) provided historical context for the development of the Black Church and its place in the African American community based on their 10-year longitudinal study. The Black Church was founded after the Free African Society in 1787 that comprised the foundation of African American Christian churches (Lincoln & Mamiya, 1990). It was also a social institution referred to as the "Negro" church prior to the 1960s that consisted of seven African American Christian denominations that provides education, financial assistance, emotional support, and community resources (Lincoln & Mamiya, 1990). According to Lincoln and Mamiya, no other institution has had so much power in the African American community as the Black Church. Hays (2015) illustrated its dominance in the lives of African Americans by reporting that more than 80% of African Americans are members of African American churches and that more than half of African Americans attend church regularly.

The African American church influences how many of its members deal with stress. Lukachko et al. (2015) investigated the relationship between religiosity and mental health utilization in African Americans using data from the National Survey of American Life (NSAL) and extracted a subsample of 3,570 African Americans based on data from

February 2001 and March 2003. They excluded those who were confined to prisons, nursing homes, and long-term care facilities as well as those who lived on military bases. Lukachko et al. found an inverse relationship between church attendance and African American's use of professional mental health services, defined as a psychiatrist, psychologist, social worker, psychotherapist, counselor, any other mental health professional, medical doctor, nurse, occupational therapist, or other health professional (p. 581). On the basis of the Lukachko et al. findings, many prolong seeking mental health treatment when distressed and default to seeking help from NS such as their pastor or the Black Church.

Prolonged lack of adequate treatment may pose harmful effects to African Americans as it does to Caucasians under similar circumstances. Lukachko et al. (2015) found that more than 75% of their sample had a mental health diagnosis within a one-year span but did not visit a mental health professional. Those findings provide some evidence that ignoring the need for professional mental health treatment can result in increased DEP or another mental health disorder.

Use of Pastoral Support

Knowledge of the importance of the Black Church includes understanding the function and reputation of the pastor in the African American community. Hankerson et al. (2013) and others (Bohnert et al., 2010; Chatters et al., 2011; Crosby & Varela, 2014; Molock et al., 2008; Young, Griffith, & Williams, 2003) showed that African American parishioners primarily seek assistance from pastors or clergy for mental health support. Crosby and Varela (2014) studied 389 college students who primarily identified as

Christians and provided insight into the pattern of African Americans seeking pastoral support. They compared the participants' level of religious help-seeking with other factors and found that compared with Caucasian Americans and Latino Americans, African Americans prefer to seek religion for support, tend to view their mental health problems as spiritual problems, and have higher interfaith intolerance. Crosby & Varela also found that African Americans with high interfaith intolerance who view DEP as a spiritual problem likely seek support from the Black Church or their pastor and that 20% prefer seeking religious help compared with 13% of Latino Americans and 16% of Caucasian Americans. The intolerance of other religions and preference for religious help-seeking may suggest African Americans' intolerance of other methods of help to deal with their problems, including mental health. The concern was that African Americans' intolerance of other methods of help like seeing a therapist limits them to the skill and knowledge of their pastors.

Regardless of whether they have the education or specialized training, African Americans hold pastors in the Black Church in high esteem because of their role as spiritual advisors (Avent et al., 2015; Crosby & Varela, 2014; Hardy, 2014). Pastors or clergy have some skills to provide pastoral counseling, but they likely do not have the specialized training needed to treat their parishioners dealing with major DEP. If pastors are the ones who routinely "treat" their parishioners rather than mental health providers, DEP will probably continue to persist in the African American community.

Regardless of their ability to treat DEP, pastors will probably continue to try to help parishioners with mental health issues. In a qualitative study, Avent et al. (2015)

studied eight pastors whose church memberships ranged from 72 to over 4,000. Avent et al. interviewed the pastors about their motivations, beliefs, and attitudes toward mental health and found they assisted their members daily with mental illnesses such as DEP and anxiety (Avent et al., 2015). It seems plausible that the beliefs of African American pastors and their recommendations about problems influence their members' mental health beliefs and affect whether they seek professional help. Five of the pastors in the Avent et al. study believed that many mental illnesses stemmed from negative spiritual influences such as the enemy called "Satan." Pastors and their members who share the belief that DEP is a spiritual problem may use religious practices such as prayer for the problem. The three remaining pastors in the study provided complex reasons for mental health problems that ranged from spiritual, social, psychological, and biological factors. The inconsistent beliefs of these pastors illustrate a broad range of perspectives about mental illness that is likely to pervade the Black Church and African American community, suggesting that African Americans may have mixed beliefs about DEP and mental health in general due to the influence of their pastors and other religious factors. The mixed range of responses from pastors is concerning because, like those in the Lukachko et al. (2015) study, they may not encourage parishioners with major DEP or another diagnosable disorder to see a mental health professional. These same African Americans may believe that pastoral support is adequate because they trust their pastors. Their pastoral trust for mental help problems may also relate to their other patterns of using religious methods in response to DEP or distress.

Other Patterns of Religious Coping

African Americans also rely on personal religious coping to help them with mental health problems. Lukachko et al. (2015) found that African Americans with high levels of religiosity had low levels of mental health service utilization. They assessed religiosity by measuring how often African Americans attended church, participated in religious practices such as prayer, reading religious material, or watching a religious television show, and rated their religious importance. Religiosity, for many African Americans, relates largely to the cultural identity that focuses on the Black Church or other church affiliation because it represents "enhanced social support" for them (Lukachko et al., 2015, p. 583). African Americans may culturally rely on their religiosity to overcome challenges as opposed to using mental health services. It may be helpful for medical and mental health practitioners to consider that some African Americans may not be avoiding treatment, but that they never considered treatment as an option culturally. Their cultural worldview may be that the church or the pastor is the only way to address their mental health needs.

Lukachko et al. (2015) identified three types of religiosity: organizational, nonorganizational, and subjective. Organizational religiosity equates to how often an individual attends church or regularly participates in church activities (Lukachko et al., 2015). Overall, African Americans possess high levels of organizational religiosity in comparison to their mental health utilization. Lincoln and Mamiya (1990) found similar evidence in one of the few large community-based studies to date regarding African Americans' organizational religiosity. They found that close to 80% of African

Americans are members of the Black Church and that African Americans attend church 50% more than other racial groups. Their evidence suggests that while most African Americans attend the Black Church, a small percentage of them may be members of other religious entities or have no religious affiliation. The overwhelming numbers of African Americans with high organizational religiosity in the Lukachko et al. study may exist because, as Lincoln and Mamiya described, religious practices and the Black Church have been a place of safety and support within the African American community since slavery. African Americans' high organizational religiosity plausibly means that they are likely to share the mental health beliefs of their pastors and their churches. Second, nonorganizational religiosity involves one's informal religious practices such as individual prayer, watching religious television programs, or requesting others to pray (Lukachko et al., 2015). African Americans, perhaps, who experience symptoms of DEP such as sadness or lack of motivation may ask someone within the Black Church such as a minister or someone in their community to pray for them rather than seeing a psychiatrist or psychologist. Thirdly, subjective religiosity covers an individual's perspective about their religion as it relates to their childhood and their experience with religion (Lukachko et al., 2015). The researchers showed that African Americans view themselves as highly religious based on their subjective religiosity. The identity of being highly religious likely makes African Americans see themselves and their capacity to deal with emotional difficulties solely in a religious context. Both organizational and subjective religiosity influence African Americans patterns of seeking professional mental health services, as Lukachko et al. found an inverse relationship between

organizational and subjective religiosity and professional mental health use. The inverse relationship suggests that African Americans with a strong reliance on God or the church may perceive little or no need for mental health services, as some participants acknowledged in the study by Campbell and Long (2014).

Campbell and Long (2014) interviewed seven African Americans ages 21 to 57 about their cultural beliefs about DEP and treatment. The participants had been either diagnosed with DEP by a mental health professional or they diagnosed themselves. Most of the primarily female sample was educated, with most having some college education, and five of the participants held or were pursuing graduate studies. The results showed that African Americans' cultural beliefs about coping with DEP reflected three themes:

1. African Americans do not suffer from DEP; it is a Caucasian American disease.
2. African Americans lack trust in medical professionals.
3. DEP does not require treatment because it will go away, or prayer can correct the problem. (p. 253)

The responses in the study, though not generalizable, provide a context for the findings in larger studies like Lukachko et al. (2015) and Crosby and Varela (2014) that many African Americans with DEP are reluctant to seek treatment because they are in denial about their need for treatment. Their mistrust of medical professionals and belief that DEP is not serious enough for treatment compels them to cope with DEP on their own. Campbell and Long (2014) found that the history of social injustice shaped the

mental health cultural beliefs of the study participants. The cultural beliefs of African Americans conceivably influence their mental health attitudes.

Help-Seeking Attitudes

African Americans' negative attitudes toward mental health treatment is one reason for their underuse of mental health services (Thompson, Bazile, & Akbar, 2004; Ward et al., 2013; Woods-Giscombé, 2010). Available studies show an inverse relationship between mental health help-seeking practices and factors such as stigma, culture, race, DEP, SC, and PD (Cheng et al., 2013; Conner et al., 2010; Gaston et al., 2016; Hays & Gilreath, 2017; Madusa et al., 2012; Ward et al., 2013). Gaston et al., for example, conducted a meta-analysis of 30 African American research studies and discovered that African Americans fear that receiving mental health treatment will result in their losing their families or that providers might not respect their confidentiality. Those beliefs and their belief that mental health treatment may not be successful are other reasons they gave for not seeking treatment (Gaston et al., 2016; Madusa et al., 2012).

African Americans' fear may also relate to the stigma associated with needing mental health treatment or counseling. A study by Ward et al. (2013) of African Americans' perceptions of stigma, their attitudes toward mental illness, and preferred coping strategies illustrated the effects of that stigma. The study had a sample of 272 African Americans between the ages of 25 and 72 who earned less than $40,000 annually and had less than a college education. Ward et al. found that African Americans believed they know some of the symptoms of mental disorders, had high concerns about the stigmas regarding mental illness, and had low psychological openness. The findings in

the Ward et al. study may relate to the educational level of the population studied and their concerns about confidentiality. Considering the findings from Gaston et al. (2016) and Ward et al., African Americans with a fear of potential providers breaching their confidentiality may believe it is better not to seek OT than for others to know about their mental health status. Their high concern about mental health stigma also may prompt their negative attitudes toward those who have a mental illness, as well their reluctance to seek help for their own mental health needs. In contrast, given the educational level of the participants in the Ward et al. study, it is possible that African Americans with a college education may have more psychological openness, as higher education typically promotes and offers counseling services or require that students complete a psychology course (Madusa et al., 2012). The evidence to support the argument how college education creates more psychological openness is mixed, considering the Campbell and Long (2014) study. Most of the 17 participants in the Campbell and Long study had some college education yet still expressed mistrust of mental health professionals. Though distrustful of mental health professionals, nine of the participants, more than half of the participants, were diagnosed with DEP by a mental health professional. African Americans' mistrust in providers creates a barrier for to them to initiate and potentially complete needed treatment for DEP. The issue of mistrust seemingly motivates their low psychological openness and negative attitudes toward mental health treatment that may intersect with other internal factors, such as PD and SC.

Internal Factors That Relate to African Americans' Mental Health

PD is how one interprets the balance of power and prejudice between disadvantaged and privileged groups. It is also how one interprets the damaging effect of that balance between the two groups (Schmitt et al., 2014). African Americans who exhibit PD may forego seeking OT when they may believe they need, believing themselves to be less advantaged than a potential provider. Foregoing treatment may be a way African Americans attempt to hide their depressive symptoms, which Larson and Chastain (1990) called "self-concealment." SC is the act of deliberately keeping secret perceived negative personal information from others. African Americans may perceive that treatment for mental health problems is negative information that will result in a mental health provider discriminating against them, resulting in many African Americans being reluctant to seek mental health treatment because of their SC (Friedlander et al., 2012; Madusa et al., 2012; Wallace & Constantine, 2005). The following section is a review of the current available literature on PD and is followed by an in-depth explanation of SC.

PD and African Americans

Schmitt et al. (2014) conducted two meta-analyses to examine PD on psychological well-being. In the first meta-analysis, they measured self-esteem, DEP, anxiety, psychological distress, and life satisfactions to assess the participants' psychological well-being. In the first analysis, they found a negative relationship between PD and psychological well-being with disadvantaged groups having a larger effect size (r = -.15) in the sample of N = 144,246. In this report, the large effect size supported their

hypothesis that alleged discrimination has a causal effect on psychological well-being (Schmitt et al., 2014, p. 10). They noted that personal discrimination had more harmful effects than group discrimination. The greater negative effect of personal discrimination relates to an earlier point in this review regarding whether a person of African descent perceives himself or herself as African American (Locke & Bailey, 2013), which includes perceiving discrimination as one who identifies as African American. The fact that African Americans are heterogeneous complicates professionals' ability to understand their personal and cultural view of their experiences and how they perceive that others view their experiences. The causal effect of perceived personal discrimination on psychological well-being found by Schmitt et al. may warrant the practice of pastors and others whom African Americans seek for help with DEP conceptualize their need from the perspective of the individual and not just as an African American.

In the second meta-analysis in the Schmitt et al. (2014) study that included a sample size of N = 2,640, the researchers analyzed studies that manipulated perceptions of discrimination and psychological well-being. The researchers determined that pervasiveness of discrimination influences the causal effect on an individual's well-being even though the effect size in the analysis was smaller than the larger analysis. The pervasiveness of discrimination categorizes rejection from certain individuals and society that obstructs one's basic needs for acceptance and inclusion (Schmitt et al., 2014). The findings combined with other factors already discussed, such as mistrust of providers and negative attitudes toward treatment suggest a reason for African Americans apprehension about seeking OT for chronic DEP and the need for psychological well-being. Depressed

African Americans who have significant pervasiveness of discrimination likely have strong views that they are part of a disadvantaged group in the professional mental health services environment. When they have depressive symptoms, they may have anxiety about experiencing further discrimination and delay seeking treatment, often causing additional psychological distress. African Americans' pervasive anxiety about discrimination leads them to ignore their symptoms and seek help from sources where they feel more comfortable like their pastor, though these sources may be inadequate. The inadequate care intensifies their symptoms and negatively affects their psychological well-being.

Other research also supports the idea that pervasiveness of discrimination adversely affects the psychological well-being of African Americans. Hurd et al. (2014) conducted a 4-year study exploring the relationship between PD and the mental health of African Americans. The researchers examined 607participants who identified themselves as either Black or African American, with a mean age of 20.06 years This group showed that PD predicts an increase in anxiety, depressive symptoms, and tobacco and alcohol use, but not the reverse relationship. Participants depicted their perception of discrimination by endorsing the following three items the most: "being stared at by strangers because of your race," "being observed or followed while in public places because of your race," and "being treated rudely or disrespectfully because of your race" (Hurd et al., 2014, p. 1915). Their responses suggest that African Americans have concerns about how strangers such as mental health providers perceive them because they possess the propensity for others to label them as a disadvantaged group.

Medical Mistrust in African American Culture

Racism and discriminatory experiences contribute to African Americans' perception that they are the disadvantaged group in the United States (Hurd et al., 2014; Schmitt et al., 2014). Armstrong et al. (2013) surveyed 762 African Americans and 1267 Caucasian Americans to investigate factors that contributed to racial differences in health care system mistrust due to racial disparities in health care, which they assessed measuring the participants' value and competence distrust using the Revised Health Care System Distrust scale. They determined that African Americans have higher health care system mistrust than their Caucasian American counterparts. The fact that Caucasian Americans have less health care system doubt than African Americans may be one reason Caucasian Americans are more prone to use outpatient mental health services than African Americans (Collins, Hall, & Neuhaus, 1999; Cook, Zuvekas, Carson, Wayne, Vesper, & McGuire, 2014; Kaiser Family Foundation; Snowden, 1999). African Americans' distrust that relates to their concerns about honesty within the health care system may be the cause for their propensity to seek pastoral support, as Christian clergy have taken a religious oath before God to maintain secrecy. Their concerns about honesty appear to significantly affect their decisions on where to seek help, as Armstrong et al. found they possess more concern about honesty (value distrust) than professional capabilities (competence distrust). Their reluctance has little to do with whether they feel health professionals can provide treatment and more related to whether they feel comfortable allowing them to provide it.

African Americans' comfort level with seeking treatment in the health care system likely decreases, if comfort ever existed, when other health care providers have discriminated against them. Armstrong et al. (2013) found that experiences with discrimination accounts for the relationship between race and distrust, with African Americans demonstrating more distrust than Caucasian Americans. In particular, they found that at least 80% of African Americans and 34% of Caucasian Americans in their sample reported an incident of racial discrimination. More than half of the African American participants reported three or more incidents of racial discrimination in contrast to 13% of Caucasian Americans. The researchers pointed out that the African American participants were primarily single males who lived in urban, segregated areas with lower income and had higher comorbidities than other study participants. The experiences of discrimination they reported may have been due to several reasons, according to Armstrong et al. They lived in big cities and had little money compared with other ethnic groups. Segregated African Americans who endure economic struggles may perceive interactions with Caucasian Americans or other privileged groups as discriminatory or racist because of their limited association with these other groups. It is also plausible that their socioeconomic status makes them vulnerable to discrimination. Their daily economic struggles and segregated living may solidify their mistrust of people who are not African American, especially those in medical settings.

Medical Maltreatment of African Americans

African Americans' cultural mistrust of doctors and rigidity in their perceptions of discrimination may also stem from their historic maltreatment at the hands of Caucasian

American medical professionals. The Tuskegee Study of Untreated Syphilis in the Negro Male, also known as the Tuskegee Experiment, "is the most important reason why many African Americans distrust the institutions of medicine and public health" (Gamble, 1997, p. 1773). It is a remarkable example of inhumane treatment toward African Americans (CDC, 2017; Feagin & Bennefield, 2014). The experiment began in 1932, as Caucasian American researchers sought to find a cure for syphilis--a major health crisis during that time (CDC, 2017; Feagin & Bennefield, 2014). According to the CDC, the study involved a collaboration between the U.S. Public Health Service and the Tuskegee Institute. The researchers misled African Americans and America about the purpose of the experiment (CDC, 2017; Feagin & Bennefield, 2014). The researchers reported syphilis affected Caucasian Americans' neurological functioning and African Americans' sexual functioning (Feagin & Bennefield, 2014). They rationalized that African Americans have "primitive brains and sexual desires" to justify their racist and discriminatory treatment, as they used only African Americans in their study, not telling them they were a part of a medical experiment and withholding the treatment for syphilis when it became available.

The Tuskegee experiment was a genocide of African American people. Researchers misinformed 600 illiterate African American men about their intent during the study, enticing them with free meals and what they told them were free medical exams (CDC, 2017). As a result, African Americans were unable to give informed consent to participate in the experiment, and their ignorance of the study resulted in many of them to dying and spreading syphilis to others. This transgression crossed generations

within the African American community, as the experiment lasted 40 years (CDC, 2017; Feagin & Bennefield, 2014). It is logical that the fact of African American lives that were senselessly lost and the length of time before their deaths were addressed resonates in the minds of African Americans who may need mental health treatment. Though their depressive symptoms may debilitate them, they may reason that debilitation is better than death.

Feagin and Bennefield (2014) noted numerous other acts of systemic racism toward African Americans in health care, describing how "institutionalized" Caucasian American socioeconomic resources, as well as racism and discrimination, create barriers and restrictions for African Americans to access appropriate medical treatment and have favorable prognoses (p. 7). They stated that less than 15% of American history does not include systemic oppression. They examined events through the systemic racism theory that postulated the following dimensions:

1. Dominant racial hierarchy,
2. Comprehensive white racial framing,
3. Individual and collective discrimination,
4. Social reproduction of racial-material inequalities, and
5. Racist institutions integral to white domination of Americans of color. (Feagin & Bennefield, 2014, p. 7)

The work of James Marion Sims, known for introducing gynecology as a specialty, demonstrates another act of systemic racism toward African Americans (Feagin & Bennefield, 2014). Sims experimented on African American children in the mid-1800s

(Feagin & Bennefield, 2014). He developed and performed a pelvic surgical procedure on an African American girl who suffered from a fistula. His procedure consisted of inserting a speculum into a slave girl's vagina, with Caucasian Americans holding her as she screamed, to close the opening without anesthesia. He practiced his methods on African American children until he perfected them. Once perfected, he performed the procedure on Caucasian American women under anesthesia. The conscious and public disregard for African American health and life demonstrated by Sims and supported by other Caucasian Americans, doubtless contributed to the generational effect of African Americans' mistrust of medical professionals.

The Negro Project in the nineteen thirties was another example of racism that led to genocide that may cause African Americans to mistrust medical professionals and the health care system (Feagin & Bennefield, 2014). During the eugenics or population control era, Margaret Sanger developed a project to reduce the African American population by lobbying for the use of birth control in African American communities (Feagin & Bennefield, 2014). As a result, African American women died from intrauterine devices (known as the "silent killer") or suffered from hypertension and other life-threatening heart problems due to the hormones in birth control pills. Knowledge of occurrences such as the Tuskegee Experiment and the Negro Project may make African Americans mistrust the health care system, suggesting more reasons African Americans tend to postpone medical treatment. They likely believe it is better to deal with symptoms on their own, as participants expressed in the Campbell and Long (2014) study, than to

make themselves vulnerable to medical maltreatment from Caucasian Americans or other privileged groups.

Institutional Racism

For the African American, racism transcends medical abuse and the healthcare system, as it can overlap with institutional racism, defined as an organization's failure to provide quality care or professional services because of the race, culture, or ethnic origin of the accused (McKenzie & Bhui, 2007). Another reason is that police violence toward African Americans has perpetuated the mistrust of the latter by privileged groups. Jee-Lyn García and Sharif (2015) published a commentary about police violence, racism, and public health in response to the killings of two African Americans--Eric Garner and Michael Brown--by Caucasian police. That the police who killed them were not found guilty for these incidents. The U.S. legal system that allowed the cops killers to get away with their crime demonstrates institutional racism toward African Americans.

Jee-Lyn García and Sharif (2015) proposed that health care professionals should be aware of the pervasiveness of racism in criminal law and encouraged health care professionals to stand against social injustices, as one of the disadvantages of health is racism. As racism deters African Americans from seeking mental health treatment, institutional racism may be a large contributor to that effect. African Americans may put off their mental health because they view the police, the legal system, and medical professionals as part of the same institution that inflicts institutional racism on their people. They may conceptualize that both police and medical professionals who are supposed to protect and care for American citizens pick and choose who they feel deserve

protection and care. That concept, along with continuing manifestations of widespread racism, may be the larger reason African Americans do not seek medical care for mental health problems, as they may choose protecting their lives over their emotional health.

The longstanding history of racism and discrimination toward African Americans is too comprehensive for this review; however, it is important, given that close to 90% of American history includes acts of systemic racism, especially toward African Americans (Feagin & Bennefield, 2014). Mental health providers should be cognizant of the various forms or racism, including institutional racism, that may cause African Americans to self-protect. Self-protection may look different for each African American based on their identified ethnic identity, religious preferences, and experiences with racism. Those African Americans who have been negatively targeted because of their race may keep their experiences with racism secret due to fear of more negative consequences. African Americans may use SC to hide the effects of racism and their mental health challenges.

SC and African Americans

SC is intentionally hiding personal information from others that people perceive as negative or embarrassing in an attempt to protect themselves (Larson & Chastain, 1990). Larson and Chastain (1990) also developed the SC construct and the self-Concealment scale (SCS). In their preliminary study, they found that individuals with high levels of SC were likely to suffer from DEP, anxiety, or other psychological problems. In a follow-up meta-analysis of 137 studies using the SCS, Larson et al. (2015) developed a working model for the psychology of SC. They found that individuals from multiple different groups with high levels of SC were less prone to seek counseling or

other mental health treatment and that SC predicts negative health outcomes such as DEP, anxiety, distress, and physical symptoms. Considering the chances of negative health outcomes in diverse populations, they suggested that cognitive processes such as thought suppression, rumination, shame, and stigma are significant factors to be examined with regard to the pathology of SC causing mental distress as well as contributing to or exacerbating physiological diseases (Larson et al., 2015).

Madusa et al. (2012) examined the help-seeking attitudes, mental health stigma, and SC in African American college students that illustrated the pathology of cognitive processes. In their study of students between the ages of 16 and 58, Madusa et al. found their levels of SC and mental health stigma related negatively to the students' attitudes toward mental health treatment, as SC is a factor that may reveal an individual's internal stigma. If engaging in SC represents African Americans' internal stigma, then it is conceivable that perceiving stigma from others can intensify their ensuing psychological distress and, at the same time, prevent them from correctly or effectively dealing with their stress or stressors. Mental health stigma, comparatively, consists of believing that people who have a mental disorder have an incurable condition (Madusa et al., 2012). Mental health stigma or internal stigma may cause African Americans to anticipate stigmatization whenever they believe they are associated with discrediting attributes. Their anticipation may cause them to hide symptoms and avoid treatment from a mental health professional and in so doing pathologizing their mental health.

Dealing with pathologizing symptoms by concealing them and not treating them can increase depressive symptoms such as suicidal ideation and behaviors. Friedlander et

al. (2012) examined the relationship between SC, depressive symptoms, and suicidal behaviors in young adults or college students and adults over 65 years of age. They found that in younger adults, SC and suicidal behaviors correlated positively, a significant finding, as Lincoln et al. (2012) reported that African Americans commit suicide at twice the rate they did in the 20th century, with males ages 15 to 19 having the highest rates in the group. In contrast to young adults, Friedlander et al. found a positive correlation between SC and depressive symptoms but not suicidal behaviors in older adults. Though the study had 3% African American participants, the results suggested a need for further exploration of chronic DEP in African Americans. Young African Americans may have more suicidal tendencies than older adults because of their inexperience with dealing with stressful situations such as college, caring for themselves, and being away from social supports such as family after entering adulthood. The increased risk of suicidal behaviors, possibly caused by SC, suggests that preventive measures should be increased in this age group due to the increased risk of mortality (Friedlander et al., 2012).

Mental health clinicians should be aware that young adults may hide their suicidal thoughts and behaviors and should look for other possible indicators of suicide risk such as sleep disturbance, weight changes, and psychomotor agitation (Friedlander et al., 2012). The inclination for those in this group to use SC suggests one reason that professionals misdiagnose African American symptoms as psychosis or other disorders rather than depression (Bailey et al., 2011). When African Americans do seek treatment of some sort, they may not believe they are depressed (Campbell & Long, 2014). Their lack of insight regarding their mental help may make them seek treatment for other

reasons--such as physical complaints (Bailey et al., 2011). Both Friedlander et al. and Bailey et al. emphasized that those to whom African Americans seek help should focus on assessing the whole person, including paying close attention to behavioral signs and somatic complaints, rather than depending on the patient to verbalize accurately what they are experiencing.

Plowden et al. (2016) concluded that mental health professionals misdiagnose African American men, calling attention to the uneven rate of suicide in the population. They reported the pattern of professionals typically not diagnosing African American men with DEP except in two settings: homeless shelters and prisons. They concluded that, on average, 50% of state, federal, and local African American inmates had some kind of mental disorder and suggested several possible causes for this pattern:

- They do not report depressive symptoms,
- They do not have accessible resources to address their mental health,
- They do not feel comfortable expressing or addressing their mental health needs, and
- Mental health professionals' lack of cultural sensitivity and competence to assess and engage African American men to seek OT properly and effectively. (Plowden et al., 2016)

Mental health professionals can practice cultural sensitivity by recognizing that African Americans may conceal their need for treatment and require intentional clinical interventions (behavioral observations) in addition to self-reports to obtain an accurate symptom assessment (Bailey et al., 2011; Friedlander et al., 2012; Plowden et al., 2016).

Other literature supports the concept of a provider being more aware of the need for accurate assessment of African Americans. Lincoln et al. (2012) led a study using secondary data from the National Survey of American Life and extracted a subsample of 3,570 African Americans based on data from February 2001 and March 2003 that were also used by Lukachko et al. (2015) who examined suicide, negative interactions within families, and emotional support (level of conflict in informal networks) among African Americans. Lukachko et al. found a higher likelihood of African Americans who perceive lower emotional support from family members to endorse suicidal ideations and attempts. They also reported within-group differences, as they stated that, more often in Black Caribbean people than African Americans, negative family interaction is a risk factor for suicide, and emotional support is a protective factor (Lincoln et al., 2012). When assessing those commonly identified as African American, mental health professionals should assess the patient's view of their family interaction and support in addition to making purposeful behavioral observations and obtaining self-reports. Outpatient professionals should also be aware that negative family conflict is a higher risk factor for suicide in some subgroups (e.g., Caribbeans) within African American culture due to their heterogeneity (Lincoln et al., 2012; Locke & Bailey, 2013; Sellers et al., 1998; Woodward et al., 2015). The within-group differences can relate to acculturation of non-U.S. born African Americans or those with high generational ties to their home country.

Lincoln et al. (2012), contrariwise, pointed out some outer-group differences, as African Americans commit suicide less frequently than other ethnic groups, possibly indicating that they manage suicidal ideations better than other populations, or it may

support the notion that treatment professionals fail to detect all African Americans' suicidal behaviors (Plowden et al., 2016). The possibility that professionals do not always detect African Americans' suicide risks suggests three scenarios:

1. African Americans may have higher rates of emergency room and inpatient treatment than other ethnic groups because suicide risk is not detected early (see Bailey et al., 2011; Ward et al., 2013).
2. There is a need for researchers and professionals to find ways to increase African Americans' use of OT for DEP, suicide, and distress.
3. Though suicide among African Americans has increased since the 20th century (Lincoln et al., 2012), their resiliency as an ethnic group demonstrates that with the proper intervention, they can also reduce their prevalence of DEP.

Developing interventions that may reduce SC and improve the capacity to confide their mental health needs to outpatient professionals may be a step toward reducing this prevalence.

The Stigma of Weakness

Relative to African Americans' SC are their beliefs and attitudes about the stigma that a weak person is less than a whole person and is a fractured identity. The stigma of needing help for a mental or emotional problem may be the greatest barrier to African Americans seeking treatment because of their experiences with discrimination or fear of discrimination compared to other populations (Campbell & Mowbray, 2016). African Americans' history of being stigmatized due to their racial and ethnic identity in American society suggests one reason they self-conceal their need for treatment and

avoid seeking it (Hurd et al., 2014; Schmitt et al., 2014). The impact of racist events such as the Negro Project may be why some African American women believe they must show strength and postpone their own physical and mental needs because of cultural expectations and to reduce their risk adversity in American society (Woods-Giscombé, 2010).

Woods-Giscombé (2010) facilitated eight focus groups of 48 African American women with various educational and income backgrounds to explore their perceptions of the African American superwoman role. From this study, Woods-Giscombé developed the superwoman schema model that characterizes beliefs that many African American women may share about identity and how it relates to their health. The model includes five themes:

1. The obligation to manifest strength,
2. The obligation to suppress emotions,
3. Resistance to being vulnerable or dependent,
4. Determination to succeed despite limited resources, and
5. The obligation to help others. (Woods-Giscombé, 2010)

For example, participants who were 45 years or older with some college education expressed an obligation to suppress feelings and problems more than other participants. Some in this age group provided historical reasons such as slavery for their perception, a finding that suggests educated African Americans over 45, in general, may have more knowledge of slavery, segregation, and other racial disenfranchisements than other age groups. They may also fear that if they do appear weak, they have more at risk,

such as losing their jobs or being looked down upon by other African Americans. The study participants admitted that culturally they believed others would perceive them as weak if they needed help, especially mental health help. Other literature suggested that African Americans view DEP as weakness or mental illness (Bailey et al., 2011; Campbell & Mowbray, 2016). Their perception of others' beliefs suggests an internal stigma about being viewed as a weak or impaired individual.

African Americans' concern about being perceived as weak relates to their cultural beliefs about strength. Not only do African American women hold the belief that they must be "the image of the strong Black woman" (Campbell & Mowbray, 2016, p. 260), but many African Americans have the same cultural standards. They believe that they must be strong, as they hold traditional gender beliefs that they should "tough out" their DEP rather than seek psychological help (Hankerson et al., 2015). Displaying strength or toughening out depression may correlate with the belief that some African Americans believe that depression will go away independently (Bailey et al., 2011; Campbell & Long, 2014). These self-stigmatizing beliefs may compound African Americans' unwillingness to be open about the psychological struggles that they display through SC, leading to a reduction in seeking outpatient resources.

African Americans' Underuse of OT

The dated literature on African Americans' use of mental health services was generally derived from secondary data, and studies of their use of OT for DEP were virtually nonexistent (Bailey et al., 2011; DeCoux, Chaftez, & White, 2010; Hardy, 2014; Padgett, Patrick, Burns, & Schlesinger, 1994; Richman, Kohn-Wood, & Williams, 2007;

Rose, Joe, & Lindsey, 2011; Snowden, 1999; Snowden, & Thomas, 2000; Smith, 2015; Thompson et al., 2004). Richman et al. (2007) used data from the 1995 Detroit Area Study exploring social influences such as stress and racism on one's health to obtain a sample of 586 African Americans and 450 Caucasian Americans. The participants, who were between the ages of 18 and 90, had varying annual incomes ranging from $16,000 to $260,000, and represented all educational ranges. The researchers discovered that discrimination and racial identity about education and income determined African Americans' use of mental health services in metropolitan areas (Richman et al., 2007). The results, though dated, imply the significance of events such as the Tuskegee Experiment, but recent police killings of African Americans may have prompted more African Americans to seek mental health treatment.

Richman et al. (2007) found that racial identity correlated with treatment utilization but that the direction of the correlation depended on the individual's expressed racial identity. More African Americans than Caucasian Americans showed a negative correlation with racial identity and mental health treatment utilization. Richman et al. also reported that discriminatory experiences more than racial identity increased the likelihood of seeking treatment and further suggested that African Africans might be inadvertently forced into treatment because of the effects of discrimination. The negative impact may overpower their predisposition to remain strong, causing them to seek treatment for DEP when otherwise they may have not sought professional help (Campbell & Mowbray, 2016; Schmitt et al., 2014; Woods-Giscombé, 2010).

Hardy (2014) provided more information from secondary data on mental health utilization in African Americans using two types of data--one from the U.S. Religious Landscape survey in 2009 with an original sample of 35,556 participants and the other from a replicative study conducted in the District of Columbia. The first analysis included 116 participants who identified themselves as African American, a member of a historic African American church, and being over the age of 17. Hardy used the first sample to obtain needed information for the replicative study. Close to 70% of the sample were women between the ages of 26 and 33 and fewer than 10% had no college education. One quarter of the participants were Baptist, and approximately 40% attended church at least three times a month. Hardy used the data to determine the participants' preference for using licensed clinical social workers, psychologists/psychiatrists, licensed counselors, and pastoral counselors for various issues (Hardy, 2014, p. 10) and assessed the participants' preference for using the previously mentioned professional for the following issues:

> finances, child's negative behavior, sexuality/homosexuality, emotional abuse, physical abuse, contemplating abortion [and] after and abortion, contemplating marriage, general marital difficulties, after a divorce, grieving [for] a loved one, contemplating suicide, after attempting suicide, symptoms of depression, contemplating [an] affair, after [a] marital affair, discover[ing a] partner's affair, contemplating [using] alcohol and other drugs, general loneliness, and issues with temper/anger. (Hardy, 2014, pp. 9-10)

Hardy (2014) also found that African Americans have no preference for seeking support for issues from licensed social workers and prefer pastoral counseling for more than half of the listed issues. The findings may suggest that African Americans do not believe social workers are competent to address their mental health needs, or they may be unaware that social workers provide mental health treatment. The findings also supported earlier evidence discussed in this review that African Americans seek and trust their pastors for their mental health needs (see Crosby & Varela, 2014; Hankerson et al., 2013).

Regarding issues that may relate to depression and provider preference, the first analysis showed that African Americans preferred pastoral counselors, psychologists, or psychiatrists over other providers (Hardy, 2014). For example, between 40-50% of the participants preferred seeing a psychologist for symptoms of depression, contemplating suicide, and after attempting suicide. The participants' responses differed significantly from the Campbell and Long (2014) study, as those participants did not believe that African Americans became depressed or that depression would resolve on its own. The difference in the findings are possibly due to the Campbell and Long study having a small sample of $N = 17$ versus $N = 166$ in the Hardy (2014) study. In contrast, the Hardy findings may support the Campbell and Long (2014) findings because the Hardy study measured African Americans preferences and not their actual treatment use. African Americans' preference for psychiatrists/psychologists over social workers or licensed counselors may relate to the assumption that only psychiatrists/psychologist hold professional, terminal degrees. What is important to realize is that findings indicate that

African Americans are aware of where to seek professional help for DEP, although that knowledge does not necessarily lead to use of professional treatment services.

The second analysis by Hardy (2014) included 609 participants who were 18 years or older. Almost 75% of the sample was females with an average age of 42. The participants demographically were educated, as 63% had a bachelor's or master's degree. Between 80-90% were Baptists who reported attending church three times a month on average. The analysis showed that African Americans preferred pastoral counseling for all issues except DEP and that they usually identified as Christian or a member of the Black Church, data supported by Lincoln and Mamiya (1990) and Lukachko et al. (2015). The data also showed that African Americans contemplate how and with whom they should seek treatment. Given that latter knowledge, however, did not result in their seeking treatment for their chronic depressive experiences and that mental health professionals and clergy alike should find ways to engage African Americans in treatment sooner.

Outpatient professionals and the Black Church working together might resolve the two extremes African Americans display regarding their mental health: either seeking treatment from a primary care professional or postponing seeking help until they need emergency care. Bailey et al. (2011) reported that African Americans frequently go to their primary care physicians for physical symptoms like sleep disturbance, appetite issues, and other medical conditions known to relate to DEP. In contrast, Snowden (1999), in a U.S. urban sample, found that in comparison to Caucasian Americans, African Americans went to the emergency room more often for mental health problems

and were less likely to see a therapist or OT. Padgett et al. (1994) found that ethnic congruence—whether the therapist shares their ethnic identity—often predicts whether African Americans are likely to have mental health visits.

Summary of the Literature Review

African Americans are those who have lived in the United States, felt American socialization, have African ancestry, and identify with the African American cultural group. They are a heterogeneous ethnic group (Locke & Bailey, 2013; Sanchez & Awad, 2016; Woodward et al., 2015) that lives with DEP longer than other ethnic groups (Bailey et al., 2011; Hays, 2015; Hays & Gilreath, 2017; Ward et al., 2013). Their pervasiveness of DEP relates to numerous factors such as their ethnic identity (Locke & Bailey, 2013; Sanchez & Awad, 2016), religiosity (Lincoln & Mamiya, 1990; Lukachko et al., 2015), acculturation (Sanchez & Awad, 2016; Sellers et al., 1998), and internal factors (Hurd et al., 2014; Schmitt et al., 2014).

African Americans appear to manifest their doubt regarding DEP and seeking professional treatment for it through PD and SC, which influence their decisions about how to manage their symptoms. African Americans who exhibit the predisposition that they themselves are disadvantaged as compared to the providers may forgo seeking OT when they need it. They may therefore attempt to hide their depressive symptoms through SC, the purposeful secret-keeping of mental health status or other personal information that one believes is negative or embarrassing with the hope of preserving their positive identity (see Larson & Chastain, 1990).

African Americans who do not seek OT from a professional such as a therapist or a counselor, for example, may be demonstrating SC and create a serious threat to their lives due to the DEP they suffer from (Hankerson et al., 2013; Lincoln et al., 2012; Molock et al., 2008). Living with DEP for a long period without receiving needed treatment or an intervention may lead to a major depressive disorder (MDD), which globally is the predominant disabling mental condition.

Understanding potential situations that contribute to African Americans' patterns of avoiding OT for MDD are critical, as they may experience more racism and discrimination in their lives that create a barrier to their willingness to pursue professional help (Hurd et al., 2014). Second, they may deny their depressive symptoms because of the cultural belief that they must be strong or that African Americans do not get depressed (Campbell & Long, 2014; Nicolaidis et al., 2010; Woods-Giscombé, 2010). African Americans may also conceal their symptoms so they will appear and remain strong within their culture, for they believe that asking for help or talking about their problems is a sign of weakness (Campbell & Mowbray, 2016; Schmitt et al., 2014; Woods-Giscombé, 2010). Their perception that appearing weak might produce more psychological distress compounds their problem with knowledge of the medical maltreatment of and social injustices toward African Americans and the loss of many African American lives may make them view seeking OT as a life-or-death decision.

Knowledge of the Tuskegee Experiment that lasted for 40 years and the U.S. Public Health Service involvement in it may have contributed to some African Americans' belief that professional medical treatment is not to be trusted. Other events

that relate to systemic racism like the Negro Project (Feagin & Bennefield, 2014) and police violence (Jee-Lyn García & Sharif, 2015) as well as institutional racism may possibly further influence African Americans' views that they are a disadvantaged group in America. African Americans may conceal their need for help internally by rationalizing that DEP will go away on its own. Their internal factors may relate to their sense of stigma about their mental health identity and the consequences of that identity for people with a mental disorder. The discrimination they have experienced because of their skin color and race (Feagin & Bennefield, 2014) may have hardened their belief that privileged groups will stigmatize them and ultimately mistreat them. This belief makes it reasonable they would avoid treatment at the onset of depressive symptoms from an outpatient mental health professional.

The information above illustrates the complexity of the causes of DEP in African Americans, with the literature showing factors that have led to negative beliefs about professional help and reasons for their avoidance of mental health treatment. There was limited scholarly research, however, about how SC, PD, and their depressive symptoms relate to their seeking or use of outpatient mental health services. A detailed description of the research design is presented in Chapter 3.

Chapter 3: Research Method

Purpose

I investigated whether African Americans' levels of SC, PD, and depressive symptoms (independent variables) influenced the usage of their NS and use of OT (dependent variables). I also explored whether and where African Americans seek help when they experience DEP. The following chapter addresses the methodology and rationale relative to the population, sampling strategy, data collection, instrumentation, data analysis, validity, reliability, and ethical considerations.

Research Design and Rationale

The study was a quantitative, cross-sectional, survey design (see Frankfort-Nachmias, Nachmias, & DeWaard, 2015) that enabled anonymous data collection at one point in time with the least likelihood of researcher bias (see Creswell, 2014; Frankfort-Nachmias et al., 2015). The survey design helped me ascertain whether African Americans' levels of SC, PD, and depressive symptoms (independent variables) accounted for a difference in their usage of NS and use of OT (dependent variables). The findings may provide mental health providers, physicians, clergy, community organizations, and African Americans with potential factors that may contribute to the prominence and lack of treatment for DEP in the African American community (see Ward et al., 2013).

Methodology

I collected research data using the online survey platform, SurveyMonkey (2018). In the following section, I describe the population, sampling strategy, recruitment

procedures, data collection, instrumentation, operationalization, and data analysis plan I followed.

Population

More than 38 million people identify as African American in the United States (U.S. Census Bureau, 2007), with the inclusion criteria for the research population including individuals who were (a) at least 18 years old, (b) identified themselves with the African American ethnic group, and (c) have lived in the United States at any time for at least 6 months. I excluded data from any who did not meet all study criteria.

Sampling Procedure

Purposive sampling. I used a nonprobability, purposive sampling procedure that entailed the deliberate selection of participants to study a target population (see Frankfort-Nachmias et al., 2015). I solicited and obtained participants from local churches and community organizations with a large African American membership or affiliation in the Hampton Roads, Virginia, metropolitan area. Seeking participants from churches was appropriate for sampling given that the literature shows most African Americans are highly religious and attend church regularly in the United States (see Lukachko et al., 2015; Pew Research Center, 2009). I conducted a Google search using the terms *African American churches* and *Black churches* to identify possible churches with African American membership in the same metropolitan area. I also solicited participants from local community organizations such as local Chambers of Commerce to identify African Americans who may not attend church. I sent an email to the

representatives of identified churches and organizations soliciting their participation in the study.

Power analysis and sample size. G*Power was used to conduct a priori analysis for the planned statistical analyses to determine the study's sample size (Faul, Erdfelder, Buchner, & Lang, 2007, 2013). The statistical analyses used in this study were the MANOVA and MANCOVA. The MANOVA power analysis resulted in the highest sample size of $N = 114$, using a statistical power of .80, an alpha level of .05, and a medium effect size of .25 (Cohen, 1988/1992; Faul et al., 2007/2013; Field, 2013). I chose the moderate effect size, as similar studies that addressed the dependent variables used a moderate effect size (see Ward et al., 2013; Ward & Heidrich, 2009). Gogtay (2010) recommended incorporating a buffer or safety factor into the projected sample size to address potential problems (p. 517). The safety factor is an informed estimate of additional units needed in the sample (Gogtay, 2010, p. 517). Adding 15% to the projected sample size is a common practice for determining a buffer (A. Boyd, personal communication, December 29, 2017). The target sample size was $N = 132$, including the 15% recommended buffer.

Procedures

I recruited participants from local churches and community organizations and through email. The recruitment message included a URL to use to access details about the study, an informed consent form, and a link to the online survey through SurveyMonkey (2018). The survey consisted of demographic questions and five

instruments to obtain data regarding SC, PD, depressive symptoms, use of NS, and OT use.

Data Collection

The participants entered their responses into SurveyMonkey (2018) after they read information about the study and signed an electronic informed consent form. They answered items about inclusion criteria: age, ethnic and racial identification, city and state of residence, and whether they had ever lived in the United States for 6 months or longer. Only those who met all inclusion criteria were included in the final sample. The participants answered demographic questions about gender, relationship status, highest level of education, salary range, employment status, occupation, religious background, and country of origin, using questions from the following five measures:

1. SCS (Larson & Chastain, 1990),
2. Patient Health Questionnaire (PHQ-9; Spitzer, Kroenke, Williams, & the Patient Health Questionnaire Primary Care Study Group, 1999; Spitzer, Williams, Kroenke, & the Patient Health Questionnaire Primary Care Study Group, 1999),
3. Physical Symptoms (PHQ-15; Spitzer, Kroenke, et al., 1999; Spitzer, Williams, et al., 1999),
4. Perceived Ethnic Discrimination Questionnaire-Community Version (PEDQ-CV, Brondolo et al., 2005), and
5. Preferred Coping Scale (PCS; Ward et al., 2013; Ward & Heidrich, 2009).

Debriefing Procedures.

The debriefing strategy included thanking participants for their participation, a rationale for the study, contact information for the researcher, a link to the Walden Institutional Review Board (IRB) for questions, counselor resources if distress arose from participation in the study, and scholarly resources about the research topic. There was no follow-up procedure as this was a cross-sectional study.

Instrumentation

SCS

Larson and Chastain (1990) developed the SC construct and the 10-item SCS. Researchers have used the SCS to examine SC in more than 40,000 participants, including diverse populations such as African Americans, according to a meta-analysis (Larson et al., 2015). The SCS is a 5-point Likert scale that was appropriate for this study because Larson and Chastain as well as other researchers (Larson et al., 2015) found that self- negatively correlates with attitudes toward seeking professional help and health outcomes.

I examined the interaction between SC and factors that may relate to the ways African Americans deal with DEP. Larson et al. (2015) showed that nearly 100 studies averaged a Cronbach alpha score of .87 in their meta-analysis, suggesting the SCS has good internal consistency. Larson and Chastain (1990) reported good test-retest reliability with a Pearson's Correlation Coefficient of .81 based on testing 43 female graduate counseling students during a 4-week interval. The item "When something bad happens to me, I tend to keep it to myself," for example, assesses whether the participant deliberately

hides traumatic experiences from others (Larson & Chastain, 1990). The SCS developer's written permission to use the instrument in this study is in Appendix A.

PHQ-9

The PHQ-9 is a public screening instrument commonly used in research and mental health practice (Spitzer, Kroenke, et al., 1999; Spitzer, Williams, et al., 1999). It uses a 5-point Likert scale containing nine items that mirror the *DSM-5* (APA, 2013) criteria for diagnosis of the MDD. The *DSM-5* criteria for a diagnosis of MDD require the individual to have experienced five or more depressive symptoms within the same 2-week period. The participants were asked to rate depressive symptoms experienced within the last 2 weeks on items such as "little interest or pleasure in doing things" and "feeling down, depressed, or hopeless." A score of 5, 10, 15, and 20, respectively, are indicative of mild, moderate, moderately severe, and severe depressive symptoms (Spitzer, Kroenke, et al., 1999; Spitzer, Williams, et al., 1999). According to Spitzer, Kroenke et al. (1999), moderate-to-severe depressive symptoms, as evidenced by scores on the PHQ-9, warrant treatment ranging from psychotherapy or psychopharmacology to more intense treatment interventions. Kroenke, Spitzer, and Williams (2001) indicated that the PHQ-9 has excellent internal validity (Cronbach's alpha = .89) and test-retest reliability.

PHQ-15

The PHQ-15 is a 15-item, 3-point Likert scale that measures somatic symptoms (Spitzer, Kroenke, et al., 1999; Spitzer, Williams, et al., 1999). Somatic symptoms are relevant to the African American population, as professionals frequently misdiagnose

depressed African Americans because their chief complaints are about somatic symptoms (Bailey et al., 2011). The PHQ-15 contains response items regarding symptoms over the past 4 weeks "feeling tired or having little energy" and "trouble sleeping," which are examples of symptoms listed in the *DSM-5* criteria for MDD (APA, 2013; Spitzer, Kroenke, et al., 1999; Spitzer, Williams, et al., 1999). The *DSM-5* criteria for a somatic disorder requires symptoms to be present for at least 6 months for a diagnosis of somatic symptoms disorder; however, symptoms only need to be present for 2 weeks to meet the criteria for MDD. Considering some depressed African Americans present with somatic symptoms in the primary care setting who have the potential of being misdiagnosed (Bailey et al., 2011), a participant who has a score in the medium to high range on the PHQ-15 may require further investigation of their PHQ-9 item responses relative to MDD criteria (Spitzer, Kroenke, et al., 1999; Spitzer, Williams, et al., 1999). Scores of 5, 10, and 15 on the PHQ-15 are indicative of low, medium, and high somatic symptoms (Spitzer, Kroenke, et al., 1999; Spitzer, Williams, et al., 1999). The PHQ-15 has good internal validity (Cronbach's alpha = .80) and test-retest reliability ranging from .60 to .83 (Kroenke, Spitzer, Williams, & Lowe, 2010).

Brief PEDQ-CV

Written permission to use the Brief PEDQ-CV is in Appendix B of this study. Brondolo et al. (2005) developed the Brief PEDQ-CV, 5-point Likert scale to assess lifetime PD of adults who live in a community setting to be administered in a short timeframe during research. A score of 1 on a response item indicated the participant had never experienced the event, and a score of 5 meant the participant had experienced the

event very often (Brondolo et al., 2005). The instrument contains five subscales: lifetime exposure, exclusion/rejection, discrimination at work/school, stigmatization/devaluation, and threat/aggression (Brondolo et al., 2005). Each subscale contains four items except the stigmatization subscale of five items. The minimum score possible on the Brief PEDQ-CV is 17, which indicates the participant never perceived any discrimination (Ghaffari & Çiftçi, 2010). The highest possible score of 85 indicated that the participant experienced extreme PD in multiple domains (Ghaffari & Çiftçi, 2010). The Brief PEDQ-CV had good internal validity (Cronbach's alpha = .88) in a sample of 420 African Americans and Latino Americans, with a total of 307 of the 420 participants identifying as African American (Brondolo et al., 2005). The literature also showed that the Brief PEDQ-CV is valid for use in African American, Latino American, and other minority groups (Brondolo et al., 2015; Brondolo et al., 2005; Ghaffari & Çiftçi, 2010). Brondolo et al. (2005) showed that the reliability coefficients of the Brief PEDQ-CV range from .70 to .78 for each subscale.

PCS

Few studies were available that used validated measures to assess actual treatment use or use or help-seeking behaviors. Many studies that relate to treatment-seeking include the use of instruments measuring the participants' intentions or attitudes toward seeking treatment in the future (Cheng et al., 2013; Gaston et al., 2016; Hammer & Vogel, 2013; Lienemann, Siegel, & Crano, 2013; Madusa et al., 2012; Mullen & Crowe, 2017; Pace, Silk, Nazione, Fournier, & Collins-Eaglin, 2018; Watson & Hunter, 2015; Wilson, Deane, Ciarrochi, & Rickwood, 2005). Researchers in other studies analyzed

secondary data, asked supplemental questions, or created a study-specific scale to determine their participants' treatment utilization (Ayalon & Young, 2005; Cheng et al., 2015; Hardy, 2014; Lukachko et al., 2015; Rodriguez-Seijas, Eaton, Stohl, Mauro, & Hasin, 2017; Villalobos-Gallegos, Marín-Navarrete, Roncero, & González-Cantú, 2017; Woodward et al., 2015).

The PCS is a 21-question, 5-point Likert scale developed to assess African Americans' preferred help-seeking methods for their mental health needs (PCS; Ward et al., 2013; Ward & Heidrich, 2009). The scale, which includes seven reverse items, has four subscales that assess the participant's usage of professional help, informal support network, religious coping, and avoidance (Ward et al., 2013; Ward & Heidrich, 2009). The scale lists items such as *"Go to a mental health therapist"* or *"Talk to my family"* that participants score on a range from *"Definitely do this"* (score of 4) to *"not applicable"* (score of 0). The PCS has good internal validity ranging from 0.62 to 0.78 and reliability coefficients ranging from 0.64 to 0.84 in previous studies (Ward et al., 2013; Ward & Heidrich, 2009).

Operationalization of Constructs

SC

Larson and Chastain (1990) defined SC as an individual's tendency to hide personal information from other people that he or she perceives as negative (p. 440). The scores on the SCS measured SC. A score of 0-30 on the SCS is indicative of low SC, and a score of 31 or higher is indicative of high SC.

PD

PD is a multilayered construct that includes a person's individual, institutional, or cultural experiences of unfair treatment because of ethnicity, which can include stigmatization, rejection, exclusion, violence, or harassment (Brondolo et al., 2005, p. 336). The Brief PEDQ-CV scores measure PD. A score of 50 or lower suggests low PD, and a score of 51 or higher suggests high PD.

DEP

The *DSM-5* (APA, 2013) defines MDD as an individual experiencing a minimum of five depressive symptoms, with one being having a depressed mood or loss of interest or pleasure within a two-week period. The other symptoms may include weight loss or gain, sleep disturbance, psychomotor agitation or retardation, fatigue, guilt or hopelessness, inability to concentrate, and suicidal ideations with or without plans or intent (APA, 2013). The symptoms must cause clinical distress or impairment in functioning (APA, 2013). Kroenke and Spitzer (2002) recommend using a cutoff score of 10 or higher for the PHQ-9, as depressed patients in the primary care setting are seven times more likely to score a 10 compared to nondepressed patients. The scores on the PHQ-9 measure DEP; a score between 10-27 on the PHQ-9 signifies the participant has high DEP, and a score between 0-9 signifies the participant has low DEP.

Use of NS and OT

The PCS measured both dependent variables-usage of NS and OT. NS relates to the participants' use of natural or informal methods of treatment such as talking to a friend or clergy person for DEP. OT relates to the participant seeking treatment from a

mental health professional such as a therapist in the community for DEP. Ward et al. (2013) used the mean score of each subscale on the PCS to determine how likely African Americans were to use informal supports compared to using professional treatment for a mental illness. Ward et al. indicated that higher subscale scores or those closer to 4 demonstrate an increased likelihood that the participant coped with his or her mental illness in this way. The dependent variable NS operationally was the highest mean score between the informal support network, religiosity, or avoidance subscales. If the highest mean score was 3.4 or less, the participant has low NS. If the highest mean score was 3.5 or higher, the participant has high NS. The dependent variable OT operationally was the mean score on the professional help subscale, with low use and high use being determined by 3.4 or lower and 3.5 or higher, respectively.

Data Analysis Plan

Research Questions and Hypotheses

The overarching research question in this study was "How do the factors of SC and PD influence whether and where African Americans actually seek help for major DEP?" I examined responses to two sub-questions to answer the central research question sufficiently to follow along with their corresponding hypotheses and statistical analyses:

Research Question 1: Do the NS and OT mean scores (dependent variables) of African Americans vary by their levels of SC, PD, and DEP (independent variables), and if so, which one distinguishes their NS and OT score more?

Null hypothesis: The mean scores of NS and OT are equal across all levels of SC, PD, and DEP.

Alternative hypothesis: The mean scores of NS or OT differ across at least one of the levels of SC, PD, or DEP.

I used a three-factor MANOVA was used to analyze Research Question 1. The MANOVA is an extension of the analysis of variance (ANOVA) that evaluates the population mean vectors of two or more dependent variables across two or more levels of the independent variables (Green & Salkind, 2003; Rencher, 2002). The MANOVA tested the hypothesis of whether the population means for NS and OT are the same at all levels of SC, PD, and DEP. A true hypothesis meant the population mean scores for any linear combination of SC, PD, and DEP were equal for all groups. The Wilks's lambda statistic was used to test the MANOVA hypotheses, as the statistic is commonly used in social science research for this type of analysis (Green & Salkind, 2003, p. 201). The MANOVA was more appropriate than the analysis of variance, as the MANOVA reduces the likelihood of Type I errors (Field, 2013), the erroneous rejection of the null hypothesis given the inclusion of multiple independent and dependent variables (Field, 2013). The MANOVA has the following assumptions in addition to fundamental statistical assumptions:

1. There must be two or more dependent variables that are continuous variables,
2. The independent variables must have two or more categories or levels,
3. The data must be randomly sampled and independent from the other participants' variable scores,
4. There is multivariate normality, and

5. There is no multicollinearity. (Field, 2013; Green & Salkind, 2003; Rencher, 2002)

Simultaneous and post hoc tests were conducted as appropriate to test these assumptions (e.g., Tukey, Bonferroni, Box's M Test of Equality of Covariance Matrices, Mahalanobis Distances, and Shapiro-Wilk test of normality; Green & Salkind, 2003; Rencher, 2002). I conducted the partial eta squared output analysis for the MANOVA in IBM SPSS Statistics for Windows, Version 25.0 or SPSS (IBM Corp., 2017) to determine the effect size of each independent variable.

The MANOVA was an appropriate statistical analysis for Research Question 1 considering several factors. Larson and Chastain (1990) used the MANOVA in the development of the SCS. Larson et al. (2015) used the MANOVA in their meta-analysis of studies that employed the SCS. Researchers discovered that SC and PD are negatively correlated with attitudes toward professional and mental health outcomes (Larson & Chastain, 1990; Larson et al., 2015; Friedlander et al., 2012; Madusa et al., 2012). It is probable that SC and PD may affect how African Americans deal with mental health problems such as DEP and not just their attitudes toward treatment. The MANOVA helped determine if African Americans were more likely to handle DEP on their own, use their NS or go and see a qualified professional (OT).

Research Question 2: Do the NS and OT mean scores (dependent variables) of African Americans vary by their levels of SC, PD, and DEP (independent variables) when controlling for the impact of gender, income, education, and relationship status (covariates)?

Null hypothesis: The mean scores of NS and OT are equal across all the levels of SC, PD, and DEP, when controlling for gender, income, education, and relationship status.

Alternative hypothesis: The mean scores of NS or OT differ across at least one of the levels of SC, PD, or DEP, when controlling for gender, income, education, and relationship status.

A three-factor MANCOVA, an extension of the ANOVA, was used to analyze Research Question 2. The MANCOVA evaluated the population mean vectors of two or more dependent variables across two or more levels of the independent variables while restricting for the effects of one or covariates (Green & Salkind, 2003; Rencher, 2002). The MANCOVA helped to reduce within-group error variance and eliminate confounds (covariates; Field, 2013). Research Question 2 took Research Question 1 a step further by determining if other possible variables such as gender or income influence the NS and OT. The Wilks's lambda was used to test the MANCOVA hypotheses. The MANCOVA has the same assumptions as the MANOVA, with a few exceptions:

1. The covariates are continuous, ordinal, or dichotomous.
2. There is the homogeneity of regression slopes.
3. The covariate must be independent of the dependent variables. (Field, 2013)

If the homogeneity of regression slopes assumption is met, the *F*-statistic and *F*-distribution may be interpreted confidently. If the homogeneity of regression slopes is not present, then the Type I error is elevated, and the ability to determine the effect size is compromised (Field, 2013). The covariates and dependent variables were examined to

determine if they have a statistical relationship before conducting the MANCOVA to address assumption Number 3 as suggested by Field (2013). The same simultaneous and post hoc tests discussed regarding the MANOVA were performed in the MANCOVA to test for other assumptions.

Software Analyses

The G*Power priori analysis was used to assist in determining the sample size (Faul et al., 2007/2013). SPSS was used to conduct the MANOVA, MANCOVA, and subsequent analyses (e.g., post hoc).

Data Cleaning

I used several strategies for data cleaning. Each survey had a unique identifier associated with data entered in SPSS. I checked and re-checked the value of labels and variable labels to ensure that they corresponded with operational definitions and constructs. The results section in Chapter 4 provides an explanation of all cleaning procedures, skipped questions, and other unanticipated response patterns.

Threats to Validity

There were minimal threats to validity in the study and no identified internal threats as this was not an experimental study. The threats to external validity may relate to generalizability, testing environment, and time-sensitivity (Creswell, 2014). The findings of the study relate specifically to African Americans that meet the study criterion in the community setting, based on obtaining the adequate sample size. Creswell (2014) indicated that research could be generalized only to past or future situations after replicating a study about time-sensitivity; therefore, the findings of this study are

preliminary. The threats to statistical conclusion validity related to "inadequate statistical power and the violation of statistical assumptions" were addressed using a specific test for the specific assumption as described in the stated data analysis plan.

Ethical Procedures

The participants' survey data were identified using a unique numerical code for each case, and no personal, identifiable information was collected. I advised participants regarding confidentiality and the limits of confidentiality, for example, in the case of subpoenaed data. I further explained how long I would store the research data in the instructions and consent agreement. The proposal was submitted to the Walden IRB 10-10-18-0077781 for approval before any data collection. Data were collected through SurveyMonkey (2018) and input into SPSS for statistical analyses. I stored the SPSS data file and subsequent analyses on a password-protected USB drive. The dissertation committee, Walden IRB, clinical psychology department director, statistical tutors, and I had access to the data for research and supervision of the research study.

Summary

The study was a cross-sectional survey design to collect data at a single point in time to answer the central question: *What factors influence whether and where African Americans actually seek help for major DEP?* The participants completed an online survey that included the study rationale, a consent form, a demographic questionnaire, the SCS, Brief PEDQ-CV, PHQ-9, PHQ-15, and the PCS, using the SurveyMonkey (2018) platform to answer two sub-questions:

1. Do the NS and OT mean scores (dependent variables) of African Americans vary by their levels of SC, PD, and DEP (independent variables), and if so, which one distinguishes the NS and OT scores most?
2. Do the NS and OT mean scores (dependent variables) of African Americans vary by their levels of SC, PD, and DEP (independent variables) when controlling for the impacts of gender, income, education, and relationship status (covariates)?

The raw data were coded and entered in SPSS (IBM Corp., 2017) to conduct the MANOVA, MANCOVA, and other appropriate analyses. The sample size was originally set at $N = 138$, but the final sample size was $N = 147$. In Chapter 4, I provide detailed descriptions of the study findings including the way how the final sample size was determined.

Chapter 4: Results

Introduction

Available research in the field of African American psychology consistently shows unique contributing factors for DEP in the ethnic group. Most researchers have agreed that not only do African Americans experience high levels of DEP, they avoid seeking treatment for mental disorders more than White Americans and other ethnic groups do (Bailey et al., 2011; Hunt et al., 2015; Ward et al., 2013). In particular, MDD is more prevalent in the African American community (Bailey et al., 2011; Ward & Brown, 2015; Ward et al., 2013). Other than assessing the treatment barriers experienced by African Americans, I focused on the importance of the need for African American outpatient mental health treatment.

In this study, I revealed whether levels of SC, DEP, and PD influenced African Americans' decision to use OT or use their NS. In this study, SC referred to the tendency of hiding personal information or experiences, and PD referred to a person's recognition of experiencing maltreatment from others due to their ethnic identity. DEP related to the endorsement of emotional distress such as depressed or sad mood, loss of interest or pleasure in during normal activities, trouble sleeping, feelings of hopelessness, or somatic complaints (APA, 2013). The rationale for the study was based personal observations that African Americans who reveal symptoms of mental illness more frequently talk to a family member or spiritual advisor than consulting a mental health counselor.

A quantitative survey approach was used to learn how the factors of SC and PD influence whether and where African Americans seek help for major DEP. To answer the central question, I developed two subquestions and corresponding hypotheses.

Research Question 1: Do the uses of NS and OT mean scores (dependent variables) of African Americans vary by their levels of SC, PD, and DEP (independent variables). If so, which affects their NS and OT score the most?

Null hypothesis: The mean scores of NS and OT are equal across all levels of SC, PD, and DEP.

Alternative hypothesis: The mean scores of NS or OT will differ across at least one level of SC, PD, or DEP.

Research Question 2: Do the NS and OT mean scores of African Americans vary by their levels of SC, PD, and DEP when controlling for the effects of gender, income, education, and relationship status?

Null hypothesis: The mean scores of NS and OT will be equal across all the levels of SC, PD, and DEP, when controlling for gender, income, education, and relationship status.

Alternative hypothesis: The mean scores of NS or OT differ across at least one level of SC, PD, or DEP, when controlling for gender, income, education, and relationship status.

The MANOVA was used as an appropriate analysis to answer Research Question 1 and to minimize Type 1 errors. The available research revealed a negative correlation between SC and PD toward mental health outcomes, suggesting the need for more

complex analysis (Friedlander et al., 2012; Larson & Chastain, 1990; Larson et al., 2015; Madusa et al., 2012). The MANCOVA) was used as an appropriate analysis similar to the selection of the MANOVA and the need to examine potential covariates. The data collection and results are discussed in this chapter.

Data Collection

Participants were recruited through word of mouth, electronic mail, and social media, including delivering flyers to clinicians at a local clinic, local community organizations, and churches. The social media outlets used were Facebook, Instagram, LinkedIn, and Google+. The potential participants were given Uniform Resource Locator for Survey Monkey that provided brief information about the study, a consent form, and the survey. They were then asked to consent to participating in the study, and only those who consented to the study completed the survey. The structure of the survey was two-fold, containing a questionnaire and five variable collection instruments used to collect data for the independent variables (PD, SC, and DEP) and dependent variables (NS and OT). The survey questionnaire included demographic items such as age, gender, relationship status, salary range, employment status, occupation, religious background, and country of origin. Gender, income, education, and relationship status were covariates. The data collection period was planned to be for 2 weeks; however, complete data collection required nearly 4 weeks. The rationale for the timing was to provide potential respondents ample time to schedule a response. The actual recruitment process included additional recruiting via social media to obtain the needed sample size.

Demographic Information

Selection of participants included deliberate identification of those from the African American community as well as word of mouth, local churches, community organizations, and virtual venues such as electronic mail and social media like Facebook, Instagram, Google+, and LinkedIn. Those who showed an interest were sent a paper or electronic flyer that provided a brief overview of the survey that contained a unique URL for participants to use to independently access the survey on the SurveyMonkey (2018) platform. The participants were primarily those who learned of the study through social media (71.9%) as shown in Table 1.

Table 1

Participant Settings Descriptive Statistics

		Frequency	Percent
Valid	Outpatient mental health clinic	7	4.8
	Community organization (e.g., Chamber of Commerce, human services, community service board)	8	5.5
	Religious organization (e.g., church, synagogue, chapel)	6	4.1
	Social media (e.g., Facebook, LinkedIn, Google+)	105	71.9
	Collegial settings	19	13.0
	Primary care settings	1	.7
	Total	146	100.0
Missing		1	
Total		147	

The online survey was two-fold, as it contained a sociodemographic and inclusion criteria questionnaire along with five variable instruments. The sociodemographic items captured were age, gender, relationship status, salary range, employment status, whether the participant lived in the United States and, if so, for how long. The covariate data for Research Question 2 came from these items. The following five instruments were used to collect data for the IVs-PC, SC, and DEP and DVs-NS and OT:

1. SCS (Larson & Chastain, 1990),
2. PHQ-9 (Spitzer, Kroenke, et al., 1999; Spitzer, Williams, et al., 1999),
3. PHQ-15 (Spitzer, Williams, et al., 1999),
4. PEDQ-CV (Brondolo et al., 2005), and
5. PCS (Ward et al., 2013; Ward & Heidrich, 2009).

The data collection period was set for 2 weeks to provide potential respondents ample time to answer. The data collection period, however, was extended from October 19, 2018, through November 19, 2018 because of the need for additional recruiting to obtain the needed sample size.

Descriptive and Demographic Characteristics

The online solicitation closed with $N = 179$, and respondents were asked inclusion criteria immediately after they provided consent. One was removed from the sample, as she did not provide consent, the first response. Another 21 respondents failed to complete at least one of the scales, and their responses were removed. The PEDQ-CV scale included a free response for participants to identify their ethnic identity. Only those who identified as African American for ethnicity or described themselves as Black, African, or a related term in the free response were included, as shown in Table 2. All other ethnicities were excluded from the research; thus, 10 respondents were removed who did not meet the inclusion criteria based on their free response entry, although they may have identified themselves as African American on the sociodemographic questionnaire.

Table 2

Ethnicity Descriptive Statistics

Valid	African A.	144	98.0
	Native A.	2	1.4
	Other	1	.7

Note. Those who did not answer African American answered Black or something similar in the free response.

The remaining eligible sample was $N = 147$, including those who fit the inclusion criteria and had valid responses for at least one of the scales. Additionally, a total of $N = 134$ had partial responses on all on scales. The averages of the valid responses were used to account for the missing responses. An adjusted total then was created by multiplying these means by the number of items in that scale, as though the missing responses were the same as the average of valid responses. For the PHQ-9 scale that contained 10 items, two participants omitted one response (10% incomplete) and one omitted six responses (60% incomplete). There were 0.5% of data missing from the valid sample of $N = 147$ on the PHQ-9. The symptoms scale (PHQ-15) had 15 items. Regarding missing data from the PHQ-15, one participant provided no responses and was subsequently excluded from the analyses that included the use of the data from this scale. Eight participants omitted a response to one question only, resulting in 6.7% of the scale being incomplete. Of the valid sample of $N = 146$ that remained, the missing data rate was 0.4%. There were also missing data from the PCS instrument--a 21-item scale--as eight failed to provide responses on this scale and were excluded from the analyses for coping. Only one person omitted one response item. Of the valid sample of $N = 139$, this was a missing data rate of 0.03%.

The PEDQ-CV had 34 items that 12 participants did not complete and thus were not included for analysis. One omitted an item indicating 5.9% percentage incompletion.

The final valid sample of $N = 135$ revealed a missing data rate of 0.04%. Fourteen did not respond to questions on the 10-item SCS, resulting in their responses not being incorporated into the analyses for the scale. The remaining participants responded to all items, leaving a sample of $N = 133$. Tables 3 and 4 capture the descriptive statistics for the variables. An exploratory data analysis of the variables was conducted, and no egregious departure from normality was present, as the skewness and kurtosis levels were within ±2.

Table 3

Sample Size Descriptive Statistics

		Depression	Symptoms	Coping	Perceived discrimination	Self-concealment
N	Valid	147	146	139	135	133
	Missing	0	1	8	12	14
Mean		8.0000	8.1349	48.8364	38.1148	28.0376
Std. Error of Mean		.60432	.49353	.96658	1.21872	.86976
Median		6.0000	7.0000	50.0000	35.0000	28.0000
Std. Deviation		7.32700	5.96337	11.39583	14.16019	10.03056
Skewness		.968	1.193	-.396	.968	.227
Std. error of skewness		.200	.201	.206	.209	.210
Kurtosis		-.091	1.563	.454	.761	-.705
Std. error of kurtosis		.397	.399	.408	.414	.417

Table 4

Descriptive Statistics of Independent and Dependent Variables Adjusted Totals: Mean (Standard Deviation)

	Low/High group	OT*	Informal support**	Religiosity**	Avoidance**	See a doctor
Self-concealment[a]						
n=133	Low (*n*=77)	2.19 (.81)	3.25 (6.8)	2.93 (1.05)	1.96 (.64)	3.30 (.918)
	High (*n*=56)	2.16 (.74)	2.65 (8.9)	2.44 (2.72)	2.58 (.78)	2.89 (1.05)
Depression[b]						
n=139	Low (*n*=96)	2.18 (.81)	3.11 (.79)	3.01 (1.01)	2.01 (.70)	3.24 (1.00)
	High (*n*=43)	2.19 (.68)	2.69 (.83)	2.13 (1.22)	2.70 (.69)	2.88 (.93)
Symptoms[c]						
n=139	Low (*n*=89)	2.13 (.82)	3.10 (.81)	2.97 (1.08)	1.99 (.67)	3.21 (1.02)
	High (*n*=50)	2.28 (.65)	2.79 (.82)	2.33 (1.16)	2.64 (.75)	.92 (.13)
Perceived discrimination [d]						
n=139	Low (*n*=113)	2.11 (.75)	3.02 (.83)	2.77 (1.14)	2.18 (.74)	3.11 (.98)
	High (*n*=26)	2.51 (.78)	2.85 (.77)	2.62 (1.21)	2.40 (.87)	3.19 (1.02)
Overall						
n=139		2.18 (.77)	2.98 (.82)	2.74 (1.15)	2.22 (.76)	3.13 (.99)

Note. Low/High Cutoff Scores
[a]SC-Low SC score of 0-30; High SC score 31 or higher.
[b] Depression-Low DEP score of 0-9; High DEP score between 10-27.
[c] Symptoms (also used to measure depression)- Low Symptoms score of 0-9; High Symptoms score between 10-30.
[d] PD-Low PD score of 0-50; High PD score 51 or higher.
*Use of OTs-Low OT score of 0-3.4; High OT score of 3.5 or higher.
**Use of NS-Low NS score of 0-3.4; High NS score of 3.5 or higher.

More female respondents (78.8 %) than male (21.2%) accounted for the sample as shown in Table 5. The fact that the respondents were randomly selected implies that the response is a representation of the African American population. The gender imbalance in the sample, nonetheless, is a factor that implies the need for further studies with a balance between the genders.

Table 5

Gender Descriptive Statistics

		Frequency	Percent
Valid	Male	31	21.2
	Female	115	78.8
	Total	146	100.0
Missing		1	
Total		147	

More than half of the sample (83) were not in a relationship. Of those, 38.1% were single, 13.6 % were divorced, 2.7% were separated, and 2.0% were widowed.

Forty-one participants reported having a partner (27.9% married and 15.6% in a relationship). Table 6 provides a breakdown of the relationship categories.

Table 6

Relationship Status Descriptive Statistics

		Frequency	Percent
Valid	Single	56	38.1
	Married	41	27.9
	In a relationship	23	15.6
	Divorced	20	13.6
	Separated	4	2.7
	Widowed	3	2.0
	Total	147	100.0

Approximately 70% of the sample reported being employed: 84 (57.1%) for wages, 13 (8.8%) self-employed, and one (0.7%) was in the military. The remainder were either not working or looking for work, a homemaker, a student, retired, or unable to work. Employment status is displayed in Table 7.

Table 7

Employment Status Descriptive Statistics

		Frequency	Percent
Valid	Employed for wages	84	57.1
	Self-employed	13	8.8
	Out of work and looking for work	5	3.4
	Homemaker	3	2.0
	Student	19	12.9
	Military	1	.7
	Retired	16	10.9
	Unable to work	6	4.1
	Total	147	100.0

Table 8 shows that age ranges were relatively comparable, though more participants were between the ages of 25-34 (23.3%) and 35-44 (25.3%). Those who were 65 years and older had the smallest representation in the sample (7.5%).

Table 8

Age Descriptive Statistics

		Frequency	Percent
Valid	18-24	25	17.1
	25-34	34	23.3
	35-44	37	25.3
	45-54	19	13.0
	55-64	20	13.7
	65+	11	7.5
	Total	146	100.0
Missing		1	
Total	147	100.0	

Table 9 displays income ranges. More than half of the respondents reported earning less than $50,000 a year, an amount less than the standard median household income of $61,372 as reported by the U.S. Census Bureau (2018).

Table 9

Income Descriptive Statistics

		Frequency	Percent
Valid	Less than $24,999	43	29.3
	$25,000-$49,999	45	30.6
	$50,000-$74,999	31	21.1
	$75,000-$99,999	17	11.6
	More than $100,000	11	7.5
	Total	147	100.0

The educational levels in Table 10 denote that nearly 100% of the sample had a high school diploma or equivalent, with only 1% having less than a high school education. More than 90% of the participants had education beyond high school, and approximately 35% held an advanced degree.

Table 10

Education Level Descriptive Statistics

		Frequency	Percent
Valid	Less than high school	1	.7
	High school graduate, diploma, or equivalent	13	8.8
	Some college credit, no degree	32	21.8
	Trade/technical/vocational training	5	3.4
	Associates degree	16	10.9
	Bachelor's degree	30	20.4
	Master's degree	43	29.3
	Professional degree	2	1.4
	Doctorate	5	3.4
	Total	147	100.

Results

The MANOVA was used to answer Research Question 1: Does the use of NS and OT mean scores of African Americans vary by their levels of SC, PD, and DEP? If so, which variable distinguished participants' NS and OT scores more? The analysis, thus, compared the participants' levels of SC, DEP, and PD (IVs) to their NS and OT. IVs were divided into low and high levels, based on the cutoffs stated in Chapter 3; specifically, the IVs and DVs were categorized in groups of low and high based on the following:

- Scores on the SCS measured SC. A score of 0-30 on the SCS is indicative of low SC, and a score of 31 or higher is indicative of high SC.
- The Brief PEDQ-CV scores measure PD. A score of 50 or lower suggests low PD, and a score of 51 or higher suggests high PD.
- The scores on the PHQ-9 measured DEP. A score between 10-27 on the PHQ-9 mean high DEP, and between 0-9 low DEP.

- The scores on the PHQ-15 were also used to measure symptoms of DEP. A score of 0-10 means low symptoms of DEP, and between 10-30 means high symptoms of DEP.
- Scores on the PCS measured NS and OT. The highest mean scores from the subscales of informal support, religiosity, and avoidance represent NS. The mean score from subscale OT represented OT. A highest mean score of 3.4 or less indicated low NS. A mean score of 3.4 or below was the low group, while a score of 3.5 or above indicated the high group.

The a priori power analysis included a statistical power of .80, an alpha level of .05, and a moderate effect size of .25 (Cohen, 1998/1992; Faul et al., 2007/2013; Field, 2013). DEP was measured using two scales: the PHQ-9 and the PHQ-15 shown as DEP and symptoms respectively in Tables 11, 12, 13, and 14. The NS and OT (DVs) were captured from the PCS instrument consisting of four subscales-OT, informal support, religiosity, and avoidance. The outpatient subscale alone measured OT, while the others measured NS. Tables 11 and 12 provide the descriptive statistics and results for the MANOVA, respectively.

Table 11

MANOVA Descriptive Statistics: Mean (Standard Deviation)

	Low/High group	Outpatient treatment	Informal support	Religiosity	Avoidance	See a doctor
Self-concealment[a] n=133	Low (n=77)	2.19 (.81)	3.25 (6.8)	2.93 (1.05)	1.96 (.64)	3.30 (.918)
	High (n=56)	2.16 (.74)	2.65 (8.9)	2.44 (2.72)	2.58 (.78)	2.89 (1.05)
Depression[b] *n*=139	Low (n=96)	2.18 (.81)	3.11 (.79)	3.01 (1.01)	2.01 (.70)	3.24 (1.00)
	High (n=43)	2.19 (.68)	2.69 (.83)	2.13 (1.22)	2.70 (.69)	2.88 (.93)
Symptoms[c] *n*=139	Low (n=89)	2.13 (.82)	3.10 (.81)	2.97 (1.08)	1.99 (.67)	3.21 (1.02)
	High (n=50)	2.28 (.65)	2.79 (.82)	2.33 (1.16)	2.64 (.75)	.92 (.13)
PD[d] *n*=139	Low (n=113)	2.11 (.75)	3.02 (.83)	2.77 (1.14)	2.18 (.74)	3.11 (.98)
	High (n=26)	2.51 (.78)	2.85 (.77)	2.62 (1.21)	2.40 (.87)	3.19 (1.02)
Overall *n*=139		2.18 (.77)	2.98 (.82)	2.74 (1.15)	2.22 (.76)	3.13 (.99)

Note. Low/High Cutoff Scores [a]SC-Low SC score of 0-30; High SC score 31 or higher.
[b] DEP-Low DEP score of 0-9; High DEP score between 10-27. [c] Symptoms (also used to measure DEP)- Low Symptoms score of 0-9; High Symptoms score between 10-30.[d] PD-Low PD score of 0-50; High PD score 51 or higher.
[*]Use of outpatient treatments-Low OT score of 0-3.4; High OT score of 3.5 or higher.
[**]Use of NS-Low NS score of 0-3.4; High NS score of 3.5 or higher.

Table 12
MANOVA Results: F *ratio (*p *value)*

	Outpatient treatment	Informal support	Religiosity	Avoidance	See a doctor
Self-concealment	.052	19.401	6.367	24.974	5.48
	(.821)	(p < .001)**	(.013)*	(p < .001)**	(.021)*
Depression	.002	8.253	20.007	29.186	3.967
	(.969)	(.005)*	(p < .001)**	(p < .001)**	(.048)*
Symptoms	1.268	4.682	10.561	28.107	1.757
	(.262)	(.032)*	(.001)*	(p < .001)**	(.187)
PD	6.152	.895	.382	1.848	.137
	(.014)*	(.346)	(.537)	(.176)	(.712)

Note. *Difference is significant at .05 level of significance.
**Difference is significant at .01 level of significance.

The MANOVA revealed that OT did not significantly vary by levels of SC, DEP, or symptoms. OT did vary by levels of PD with F (1,137) = 6.152, p =.014. OT was higher in those participants who have a high perception of discrimination than in those who had a low perception of discrimination. The results suggested that participants will likely visit a mental health provider when they have experienced discrimination as opposed to whether they are depressed or believe their personal information is negative. The results may also suggest that participants may not recognize or acknowledge

depressive symptoms, as existing literature indicated that some African Americans believe DEP is a Caucasian American disorder (Campbell & Long, 2014).

The analysis further showed variations in NS represented by the informal support, religiosity, and avoidance subscales. Informal support varied by levels of SC, DEP, and symptoms, but it did not vary by levels of PD. Informal support was greater in the low SC given F (1,131)=19.401, p <.001 as well as the low symptoms condition, F (1,137)=4.682, p=.032. These results suggest that participants who experience DEP or emotional distress are more likely to disclose personal information about their problems to a family member or friend without regard to PD.

Religiosity varied by SC with F (1,131)=6.367, p =.013, and by symptoms with F (1,137)=10.561, p =.001. Religiosity also varied by DEP with F=20.007, p <.001, the variance represented higher religiosity in the low DEP group. There was no variance of religiosity by levels of PD given that F (1,137) =.382, p =.537. These results imply that the participants may use a spiritual coping strategy such as speaking to a religious advisor or praying without PD being a factor. The results further imply that the participants that use religious coping experience fewer depressive symptoms.

Avoidance varied by SC with F (1,131) =29.974, p <.001, and there was lower avoidance in the low SC group. Avoidance further varied by DEP with F (1,137) =29.186, p <.001, and lower avoidance was in the low DEP group. Avoidance similarly varied by symptoms with F (1,137) =28.107, p <.001, and lower avoidance was in the low symptoms group as well. Avoidance did not vary by levels of PD. These results

indicate the participants likely do not ignore their depressive symptoms or wait for them to resolve on their own and that PD is not a factor in their avoidance.

An additional comparison shown in Table 13 was conducted to examine whether there was a correlation between the item *willingness to see a doctor* on the PCS and the independent variables. The rationale for the comparison is that Hankerson et al. (2015) and Bailey et al. (2011) stated that some African Americans are predisposed to visiting their primary care doctors when depressed. A weak negative correlation exists between *willingness to see a doctor* and SC (r = - 0.249, p = 0.005), DEP (r = -0.152, p = 0.080), and symptoms (r = - 0.105, p = 0.230), and a weak positive correlation exists between *willingness to see a doctor* and PD (r = 0.021, p = 0.810). The *willingness to see a doctor* is influenced more by PD than DEP, symptoms, and SC. These findings support Hankerson et al. (2015) and Bailey et al. (2011) ideas that some African Americans who keep troublesome personal information to themselves and who have depressive and somatic complaints may visit their primary care physicians. It may also support the notion of Campbell and Long (2014) that some African Americans believe that they are incapable of becoming depressed, as it is a Caucasian American disorder.

Visiting a primary care physician can be viewed as a natural support, as the literature indicates that African Americans often seek help from a primary care doctor when they do not feel well (Bailey et al., 2011). Participants likely chose *willingness to see a doctor* on the PCS if they sought help from a primary care doctor or other regular medical provider, as the PCS included specific items that allowed them to note whether they sought treatment from a mental health practitioner on items like "*Go to a mental*

health therapist (psychologist, psychiatrist, social worker, or counselor)." With this in mind, *willingness to see a doctor* varied by SC with F (1,131) =5.48, p =.021, and those in the low SC condition were more willing to see a doctor. *Willingness to see a doctor* also varied by DEP with F (1,137) =3.967, p =.048, but it did not vary by symptoms or PD.

Table 13

Correlations With Willingness To See a Medical Doctor

		Depression	Self-concealment	Perceived discrimination	Symptoms
See a medical doctor	Pearson's R	-0.152	-.249**	0.021	-0.105
	P	0.080	0.005	0.810	0.230

Based on the results of the MANOVA for Research Question 1, the null hypothesis of the mean scores of NS and OT are equal across all levels of SC, PD, and DEP was rejected, and the alternative hypothesis of the mean scores of NS or OT differ across at least one of the levels of SC, PD, or DEP was accepted. Research Question 1 consisted of two parts: Does the DVs mean scores vary by their levels of IVs and if a variation exists, which IVs distinguish the most variation in the NS and OT mean scores? Symptoms distinguished NS most frequently, and PD distinguished OT most frequently. These distinctions suggest that African Americans have a propensity to seek support from familiar persons such as a family member or friend when they experience somatic symptoms like fatigue, headaches, sleep disturbance, or nausea. The distinction also suggests that African Americans may more likely acknowledge somatic symptoms related to emotional distress such as DEP rather than outright identifying it as DEP. The distinction regarding OT suggests that African Americans may view their experience

with discrimination requiring professional intervention and being more problematic than emotional stress, or they may view discrimination as a cause for emotional stress that justifies a need for OT. In contrast, African Americans who experience DEP may believe it requires professional treatment, as the depressed participants in the study expressed a willingness to see a doctor. However, they may seek a family doctor rather than a mental health professional to conceal their need for mental health help, as those who manifested SC were willing to see a doctor.

Moreover, the MANCOVA was used to answer Research Question 2: *Do the NS and OT mean scores of African Americans vary by their levels of SC, PD, and DEP when controlling for the effects of gender, income, education, and relationship status?* The same rationale for the MANOVA used in Research Question 1 applied to the use of the MANCOVA for Research Question 2. Likewise, the same power analysis was employed. The covariates of gender, income, education, and relationship status were analyzed based on the mixed findings in the literature on these factors. Nominal variables relationship status and employment status were recoded into binary dummy variables for this part of the analysis. The results of the MANCOVA are shown in Table 14.

Table 14

MANCOVA Results: F *ratio (p value)*

	Outpatient treatment	Informal support	Religiosity	Avoidance	See a doctor
Self-concealment	1.469 (.228)	21.934 (.000)	1.310 (.255) †	16.466 (.000)	6.142 (.015)
Depression	.119 (.731)	5.198 (.025)	6.866 (.010)	12.060 (.001)	.808 (.371) †
Symptoms	.183 (.670)	4.179 (.043)	2.270(.135) †	10.205 (.002)	.068 (.795)
PD	4.881 (.029)	.392 (.532)	1.354 (.247)	.127 (.723)	2.408 (.124)

Note. Covariates are relationship status, employment status, age, education, and income.
† Status of significance changed with controls in partial correlation

The MANCOVA analysis revealed that OT did not significantly vary by the levels of SC, DEP, or symptoms, when controlling for gender, income, education, and relationship. OT maintained the variation by levels of PD when controlling for the covariates. The MANCOVA further demonstrated that the levels of SC, DEP, and symptoms varied NS with regard to the informal support and avoidance subscales when controlling for the covariates. However, the variance between religiosity and SC [F (1,131) = 6.367, p =.013] and symptoms [F (1,137) =10.561, p =.001] disappeared when controlling for the identified demographic variables [F (10, 98) =1.310, p=.255, and F (10,104) =2.270, p=.135 respectively]. The variance of religiosity by DEP remained after controlling for demographic variables.

The additional comparison to examine the variance between the item *willingness to see a doctor* on the PCS and the independent variables described earlier was examined further controlling for the covariates in Research Question 2. The correlational results that included the controls indicated the *willingness to see a doctor* continued to vary by SC where those in the low SC condition were more willing to see a doctor than the high SC. *Willingness to see a doctor* also varied by DEP with (1,137) = 3.967, p=.048, but it did not vary by symptoms or PD. The willingness to see a doctor variation by DEP [F (1,137) = 3.967, p =.048] did not remain when controls were included [F (10,99)=.808, p=.371]. The willingness to see a doctor remained unvaried by symptoms or PD controlling for covariates. The following tables and descriptions provide further explanation regarding controls.

Results shown in Table 15 show there are no differences by gender because the *p* values are not statistically significant at 95% because they are all $p > 0.05$. These results suggested that gender plays no role in PD, SC, coping or rather NS, DEP, and symptoms. These results contribute to the mixed literature regarding the role of gender and mental health factors. PD is not subject to further investigation here but may inform future research endeavors.

Table 15

Gender ANCOVA Results

		Sum of squares	*Df*	Mean square	F	Sig.
Depression	Between groups	1.505	1	1.505	.028	.868
	Within groups	7811.324	144	54.245		
	Total	7812.829	145			
Symptoms	Between groups	8.479	1	8.479	.236	.628
	Within groups	5130.765	143	35.879		
	Total	5139.244	144			
Coping	Between groups	200.591	1	200.591	1.547	.216
	Within groups	17636.181	136	129.678		
	Total	17836.771	137			
PD	Between groups	119.224	1	119.224	.589	.444
	Within groups	26740.860	132	202.582		
	Total	26860.084	133			
Self-concealment	Between groups	71.324	1	71.324	.718	.398
	Within groups	12917.010	130	99.362		
	Total	12988.333	131			

Results in Table 16 show that relationship status varies with DEP, $p = 0.023$, but there is no variation between relationship status and symptoms, SC, NS (coping), and PD because all the *p* - values are > 0.05. It is noted that the *separated* and *widowed* relationships were disregarded because of a small sample size thereby making the relationship status (IV) having the most prominent influence on DEP (DV). These results are similar to previous findings that relationship status can be a protective or risk factor depending on the dynamics of the relationship.

Table 16

Relationship Status ANCOVA

		Sum of squares	Df	Mean square	*F*	Sig.
Depression	Between groups	474.735	3	158.245	3.280	.023
	Within groups	6560.436	136	48.239		
	Total	7035.171	139			
Symptoms	Between groups	199.169	3	66.390	1.955	.124
	Within groups	4584.896	135	33.962		
	Total	4784.065	138			
Coping	Between groups	520.305	3	173.435	1.323	.270
	Within groups	16778.187	128	131.080		
	Total	17298.492	131			
PD	Between groups	391.817	3	130.606	.663	.576
	Within groups	24431.337	124	197.027		
	Total	24823.154	127			
Concealment	Between groups	583.612	3	194.537	1.921	.130
	Within groups	12352.745	122	101.252		
	Total	12936.357	125			

Similarly, Table 17 shows that DEP and symptoms vary by education because they are statistically significant; however, NS (coping), SC, and PD lack statistical significance. Some variables such as *less than high school* and *professional degree* variables were eliminated from the analysis due to small sample sizes. The remaining sample sizes indicate that education (IV) affects mostly symptoms and DEP (DVs). Given the nature of pursuing an education and the potential impact of lack of education, the results may suggest that going to school, paying for school, or lacking adequate schooling can contribute to emotional distress such as DEP.

Table 17

Education ANCOVA

		Sum of squares	*Df*	Mean square	*F*	Sig.
Depression	Between groups	867.297	6	144.549	3.026	.008
	Within groups	6544.259	137	47.768		
	Total	7411.556	143			
Symptoms	Between groups	589.707	6	98.284	2.986	.009
	Within groups	4476.118	136	32.913		
	Total	5065.824	142			
Coping	Between groups	1113.759	6	185.627	1.465	.195
	Within groups	16347.441	129	126.724		
	Total	17461.200	135			
PD	Between groups	493.393	6	82.232	.398	.879
	Within groups	25795.810	125	206.366		
	Total	26289.203	131			
Concealment	Between groups	1187.520	6	197.920	2.040	.065
	Within groups	11931.103	123	97.001		
	Total	13118.623	129			

DEP, symptoms, and SC varied by income based on the *p* value that exceeds statistical significance, but there was no variation between NS (coping) and PD with income, which is shown in Table 18. The income level (DV) mostly affects SC, symptoms, and DEP all of which are IVs. The variations of DEP, symptoms, and SC and the lack of variation between NS and PD by income may suggest several points:

1. Financial stability can be a risk factor for DEP,
2. Levels of income can be a determining factor of whether DEP is ignored,
3. Hiding DEP is more likely to occur than hiding discriminatory experiences.

Table 18

Income ANCOVA

		Sum of Squares	*Df*	Mean Square	*F*	Sig.
Depression	Between groups	876.949	4	219.237	4.472	.002
	Within groups	6961.051	142	49.021		
	Total	7838.000	146			
Symptoms	Between groups	484.399	4	121.100	3.655	.007
	Within groups	4672.060	141	33.135		
	Total	5156.459	145			
Coping	Between groups	850.247	4	212.562	1.669	.161
	Within groups	17071.104	134	127.396		
	Total	17921.351	138			
Perceived discrimination	Between groups	1495.508	4	373.877	1.916	.112
	Within groups	25372.963	130	195.177		
	Total	26868.470	134			
Concealment	Between groups	1252.573	4	313.143	3.332	.012
	Within groups	12028.239	128	93.971		
	Total	13280.812	132			

Summary

Statistical analyses demonstrated obvious influences of the various factors in this study, as the null hypotheses for both Research Questions 1 and 2 were rejected. The results of the MANOVA rejected the null hypothesis that the mean score of NS and OT are equal across all levels of SC, PD, and DEP. The results of the MANOVA further demonstrated that DEP, specifically somatic complaints for DEP, differentiate the NS

more than the other IVs, while PD differentiates OT more than SC and DEP. The MANCOVA rejected the null that the mean scores of NS and OT are equal across all the levels of SC, PD, and DEP, when controlling for gender, income, education, and relationship status. The results demonstrated that the levels of SC, DEP, and symptoms varied NS with regard to the informal support and avoidance subscales and the variance of religiosity by DEP remained after controlling for covariates. The results of the MANCOVA further established that covariate factors do not contribute to the variation of OT regarding levels of PD. Chapter 5 that follows provides a detailed discussion of the application of the results, specifically, how these results bridge the gap in the literature about the influence of SC and PD on African Americans' treatment choices for DEP. In Chapter 5, I discuss the study limitations and suggest topics for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative study was to investigate the influence of the levels of SC, PD, and depressive symptoms in African Americans' use of NS or OT for MDD. The investigation advanced the knowledge of current factors that relate to the chronicity of DEP among African Americans and their propensity not to seek professional mental health help when treatment is necessary. To determine the following factors, I asked participants to complete a comprehensive survey that revealed the following personal traits:

- sociodemographic factors,
- SC, DEP, and somatic traits
- places or people they seek help from when depressed.

The results provided evidence that SC, PD, and DEP--including somatic symptoms related to DEP--influence African Americans' decisions of where or whether to seek help or treatment for mental health problems. The following is an interpretation of those findings, including limitations, recommendations for future research, practical implications, and implications for social change based on those findings.

Interpretation of Findings

DEP

The findings revealed significant information regarding African Americans who experience DEP, with 31% reporting high DEP based on the patient health questionnaire (PHQ-9) and 36% reporting high physical symptoms (PHQ-15). Those who reported

moderate to severe depressive symptoms on the PHQ-9 warrant treatment, such as psychotherapy, psychotropic medications, or possibly more intense treatment (Spitzer, Kroenke, & Williams, 1999). The results also showed that at least one-third of the participants had diagnosable DEP requiring treatment for which they had not sought proper or professional treatment. The percentage of African Americans who experience MDD is probably greater considering Bailey et al.'s (2011) report that primary care doctors typically misdiagnose depressed African Americans who report somatic conditions and associate those symptoms with other disorders. The demographic characteristics of participants, nonetheless, supported existing research regarding the prevalence of DEP among African Americans (see Ward & Brown, 2015; Ward et al., 2013).

The acknowledgment of chronic DEP among African Americans in previous research focused heavily on its relationship to African Americans' attitudes toward or cultural beliefs about treatment for what might be considered a mental condition. The interpretation of these results further illustrates and clarifies the reasons African Americans' suffer disproportionately from poor mental health compared with other ethnic groups. The results present African Americans' specific behaviors when they experience MDD and their reasons for the decisions they make to seek or not seek treatment and from whom. Understanding these decisions is essential to solving the larger problem that MDD is the major mental disorder in that ethnic group and the fourth- largest debilitating disorder in the United States (Bailey et al., 2011; Holden et al., 2012; Meyers et al., 2014; Ward & Brown, 2015; Ward et al., 2013). I used the MANOVA and MANCOVA to

analyze whether the levels of SC, PD, and DEP vary in terms of African Americans' NS and OT, and whether those levels differ when controlling for gender, income, education, and relationship status.

Use of Natural Supports

The null hypothesis for Research Question 1, the mean scores of NS and OT are equal across all levels of SC, PD, and DEP, was rejected. NS was measured on three subscales on the PCS: informal support, religiosity, and avoidance. The results of the MANOVA posed a multidimensional view of NS among African Americans for MDD pertaining to their SC, PD, and DEP using these subscales. African Americans' level of informal support varied by their levels of SC, DEP, and symptoms that resulted in the acceptance of the alternative hypothesis: The mean scores of NS or OT differ across at least one of the levels of SC, PD, or DEP. Informal support was found to be greater in the low SC and low symptoms groups, suggesting that African Americans who chose items like "talk to my family" or "talk to my friend" on the informal support subscale are more likely to hide negatively perceived information about themselves. These participants may have perceived that talking to family members or friends means they do not hide sensitive information from others. Their ability to communicate freely with others may result in their feeling less depressed or experiencing fewer physical problems than other groups in the study as evidenced by their lower somatic complaints.

It could also be that African Americans may alleviate their somatic symptoms by sharing information in a casual setting. Feagin and Bennefield (2014), in a comprehensive study of African Americans' experiences with systemic racism in the

healthcare system, supported the notion that some African Americans may still fear healthcare settings such as mental health clinics, preferring more casual or familiar surroundings. It is certainly plausible that the over 200 years of documented medical maltreatment of African Americans in the Feagin and Bennefield report continues to present a barrier for some African Americans to seeking professional treatment in a healthcare setting. The use of informal supports, therefore, could likely represent both a protective and risk factor among African Americans. For some, using informal supports might diminish and protect them from stressful symptoms. For others, using informal supports might represent the belief that seeking help from familiar faces rather than an unfamiliar mental health provider is more comfortable, even though DEP may not be reduced or ameliorated.

Considering further the concept of a trait being both a protective strategy and a risk factor, participants' greater use of informal support in conjunction with their lower levels of SC and symptoms should also be viewed as a possible manifestation of SC itself. Other researchers indicated that some African Americans feared others in their ethnic group might stigmatize them if they had what was considered a mental disorder--leading them to hide their mental health problems (Bailey et al., 2011; Campbell & Long, 2014; Jackson, 2013; Ward et al., 2013). Although it is not known objectively, the participants in this group may have concealed their symptoms for that reason, and that concealment may have been their way of protecting themselves from harm and further emotional discomfort. The participants who fell in the low SC could also be manifesting internal stigma, as they too identify as African American and may hold similar beliefs

that a mental disorder fractures one's identity. Campbell and Long (2014) noted that a major belief of the participants was that they did not want to be labeled as "crazy" (p. 260).

The findings of this research build Campbell and Long's (2014) preliminary findings that some African Americans believe that a mental disorder discredits them as a person, even more so because of their ethnicity. The participants in the informal support group could have been experiencing aggravating depressive symptoms while they participated in the study in their effort to hide their real experience, thereby creating another risk factor. These participants further represented a contrast to Bailey et al. (2011) who found that African Americans are more willing to reveal somatic complaints than depressive or mental health symptoms. The informal group revealed that some African Americans may not experience somatic complaints, as had been previously suggested, or it may have revealed that some African Americans may also perceive that discussing somatic symptoms would be viewed negatively by others. Regarding the former, some African Americans may be more knowledgeable about mental health symptoms, including somatic ones, because of their education and were more likely to openly disclose their experiences. Because most participants had attended college, they may have had some knowledge of DEP and mental health, which is discussed later in this chapter. Regarding the latter, and for the same reason just described, participants may have concealed their symptoms in the fear that doing so might have suggested they suffered from DEP or other mental health problems. Regarding NS based on religiosity, the participants' NS varied by their SC, DEP, and symptoms.

Participants who considered themselves highly religious reported lower levels of DEP and answered that they "might" or "definitely" would "talk to my pastor or minister" or "pray." These findings validate other studies that indicated African Americans visit their pastors for mental health problems and that some view psychological distress as a spiritual problem (see Avent et al., 2015; Crosby & Varela, 2014; Hankerson et al., 2013; Lukachko et al., 2015). The high religiosity reported by the participants supports the findings for those who endorsed informal support and reinforces the idea that some African Americans believe that their ethnic group is unaffected by DEP to the same degree as ethnic groups such as White Americans (see Campbell & Long, 2014). Whereas the findings on informal support suggest that some African Americans use NS because they feel more comfortable doing so, the religiosity aspect results suggest that some do not believe in or see a need for mental health treatment.

Campbell and Long (2014) also found that some in the African American community held the cultural belief that DEP affects only White Americans, and others believed DEP to be a spiritual problem cured not by mental health treatment but by faith. In either case, the barrier for some depressed African Americans to seeking treatment is likely less related to the fear of maltreatment and more related to the belief that the problem is not treatable, as Avent et al. (2015) revealed that some African American pastors believed that DEP and mental illness derived from Satan. The barrier, then again, could be more complex, as some African Americans may be unwilling to accept that DEP is caused by fear of maltreatment and that whenever they experience symptoms, they may rationalize them away through religious practices.

On the third NS subscale, African Americans' avoidance varied by their levels of SC, DEP, and symptoms. Some participants endorsed items such as "try to ignore the problem" and "do nothing," indicating they were less likely to NS, as evidenced by their lower avoidance. Those with lower levels of avoidance displayed low SC, low DEP, and low symptoms. These findings provide some hopeful insight regarding African Americans seeking treatment for their mental health. The participant's low endorsement of avoidance along with high endorsement of religiosity and use of informal supports suggests that more African Americans want to do something about their mental health than was previously supposed. These findings do not support previous studies that suggest African Americans avoid treatment and provide an alternative perspective on MDD (see Bailey et al., 2011; Ward & Brown, 2015; Ward et al., 2013).

Based on the low endorsement of avoidance, the African American community might benefit from more mental health education such as culture-specific guidance on recognized forms of treatment for DEP and that it is acceptable to seek professional help. The low avoidance group not only reported low avoidance, but they reported low DEP, somatic symptoms, and SC. The majority of literature available shows that, as a community, African Americans generally do not share their problems with others (Baoku, 2018; Campbell & Mowbray, 2016; Schmitt et al., 2014; Ward et al., 2013; Woods-Giscombé, 2010). This group may represent a subpopulation among African Americans who may or may not be trying to hide something about themselves, but they may lack awareness that there is a clinical reason for their distressing symptoms. The subpopulation may experience a life of hardship resulting in psychological distress they

may minimize because it is a normal aspect of their lives. Their ignorance of mental health symptoms may be related to their ignorance of other ethnic groups and their experiences with similar symptoms for which they seek mental health treatment. The avoidance results reflect the research by Campbell and Long (2014) that concluded that some African Americans are oblivious to whether or when they experience DEP or other mental health problems, a factor that delays their seeking treatment.

African Americans' ignorance of when they may be experiencing DEP could relate to the small number of African American mental health practitioners. The American Psychological Association (2015) reported that African Americans make up less than 6% of psychologists in the United States, while Caucasian Americans represent 83% of that field. Because African Americans typically reach out to others in their community for help, if there were more African American practitioners, their percentage represented in the low avoidance group likely may have been greater.

Greenaway and Cruwys (2019) developed a source model of group threat through their research on "the opposing effects intergroup and intragroup threats on identity process and group relations" (p. 218). These researchers concluded that when an individual perceives a threat from an outside group, he or she identifies more with their in-group, causing them to trust the in-group more and reinforcing the power of in-group relations. Greenaway and Cruwys posed that social context influences an individual's assessment of intergroup or intragroup threats. Some African Americans, therefore, may perceive psychological help from a field dominated by Caucasian Americans (outgroup) in an outpatient clinic (social context) as a threat to themselves and their culture

(ingroup). Encouraging more African Americans to become mental health professionals might improve the probability of African Americans seeking help from those with whom they identify, their in-group.

In addition to examining informal support, religiosity, and avoidance, I found it appropriate to examine African Americans' use of their primary care doctor or other medical doctor for DEP, as Bailey et al. (2011) suggested that African Americans are likely to go to their primary care doctor when they experience psychological distress. I used correlational analysis to examine African Americans' use of their primary care doctor or other medical doctor for DEP and its relationship the IVs SC, DEP, symptoms, and PD. The DV use of primary care doctor of other medical doctor was measured by the item "Willingness to see a doctor" on the PCS. The correlational analysis provided greater understanding of what literature had called *avoidance* among African Americans related to mental health treatment. The results indicated a weak negative correlation between "willingness to see a doctor" and the IVs. These findings, though weak, did not support the notion by Bailey et al. that African Americans seek help from their primary or family doctors when depressed or when they experience somatic symptoms.

African Americans may no longer seek treatment from their primary care doctors as they did in the past given their misdiagnosis of symptoms or not receiving treatment that resolved their symptoms because they had sought treatment from a layperson. Plowden et al. (2016) and Bailey et al. (2011) both suggested that there was a pattern of African Americans being misdiagnosed, resulting in their receiving the wrong treatment. Those African Americans who at one time sought treatment from a medical professional

believing they would receive a correct diagnosis and needing treatment for the diagnosis may have become opposed to any type of treatment for distressing symptoms. These same African Americans may have deterred other African Americans from seeking medical treatment or other professional advice if they had had the same negative treatment experience.

Some African Americans were once willing to seek help from primary care doctors for somatic symptoms that likely related to DEP (Bailey et al., 2011). The likelihood of being misdiagnosed may have led to their discontinuing seeking help from their primary care providers for somatic problems, though some studies showed they continued to seek medical OT for other conditions (Bailey et al., 2011; Barnes, Mayo-Gamble, Harris, & Townsend, 2018; Plowden et al., 2016). Most medical professionals need more training in screening, diagnosing, and referral sources to help address the epidemic of DEP among African Americans, considering they are the ones with a higher likelihood of seeing a patient in this group than a mental health professional does.

The PHQ-9 used in this study is a brief and simple-to-administer screening instrument developed for the primary care setting, which physicians can administer each time they see African American patients as well as patients in general (Kroenke, Spitzer, et al., Spitzer, Kroenke, et al., 1999; Spitzer, Williams, et al., 1999). Due to African Americans' slight proclivity to conceal information even from a professional seen regularly, primary care physicians should use the PHQ-9 to screen African Americans for DEP and provide them with basic education about depressive symptoms to improve their awareness of symptoms and increase their propensity to get professional help.

Another possible explanation for the lack of avoidance in the study group was that some African Americans avoid mental health treatment and mental health issues themselves due to mental health stigma, including simply not providing truthful answers to survey questions about their mental health (see Campbell & Mowbray, 2016; Gaston et al., 2016; Madusa et al., 2012; Ward et al., 2013). Some African Americans may believe that acknowledging to others or even themselves that they have a mental disorder means that they are insignificant or a fractured individual. Campbell and Mowbray (2016) and Feagin and Bennefield (2014) determined that African Americans who associated a stigma with mental health disorders fear being or becoming socially and economically vulnerable in the United States due to their ethnic identity. African Americans may lie to themselves about the severity of their mental health symptoms because telling the truth about having DEP or another mental health problem means a greater risk of suffering discrimination and hardship.

The inverse relationship between African Americans' "willingness to see a doctor" and SC, DEP, and symptoms tends to reject findings from some other literature that African Americans may distrust medical and mental health professionals as a result of historical factors. Feagin and Bennefield (2014) revealed that medical maltreatment of African Americans by medical professionals dates back hundreds of years, including the Tuskegee Experiment in 1932, The Negro Project of 1939, and the work of James Marion Sims in the 1800s. Considering the article by Feagin and Bennefield regarding the systemic racism experienced by African Americans in the United States, the participants in the study who chose not to see a medical doctor when depressed may represent those

African Americans who have developed a survival strategy and stay away from unfamiliar treatment, including mental health treatment, because they fear treatment could jeopardize their lives. African Americans, however, are willing to visit their medical doctors for physical symptoms that are discussed in greater detail in the next section to provide further context for these factors.

Outpatient Treatment Use

The findings revealed new evidence that PD is a factor that contributes to African Americans' OT. The results of the MANOVA showed that OT only varied by the levels of the participants' PD. In fact, OT was higher in the participants that endorsed high levels of PD. The six dimensions described in the literature provide a viable framework to understand the significant positive influence of high levels of PD on OT and the lack of influence of SC, DEP, and symptoms of OT.

African Americans appear to view depressive symptoms as stigmas they should not reveal to others, even to the point of denying them in outpatient primary care and mental health settings. The findings align with research by Schmitt et al. (2014) that African Americans are more prone to disclose discriminatory experiences than depressive ones. The findings further exhibit possible reasons seeking an outpatient mental health professional to this point may have been ruled out as an option for African Americans. It is also less probable that African Americans believe depressive symptoms are physical symptoms with the weak negative correlation between "Willingness to see a doctor" and levels of DEP and symptoms. It is likely that because of mass media and formal

schooling that African Americans may have some knowledge about how DEP manifests itself.

The willingness of African Americans to seek OT in light of PD may suggest that mistrust of mental health professionals may be less of a barrier to OT than was proposed in past studies (Campbell & Long, 2014; Gaston et al., 2016; Ward et al., 2013). African Americans' OT in terms of PD suggests that they are typically not aware that OT is available, but that some do believe seeking mental health treatment is beneficial. Though generally viewed as a negative attribute, PD can now be understood as a helpful avenue that may make African Americans more willing to seek OT. Some earlier studies believed PD was a factor that forced African Americans to seek treatment, but rather than viewing it as a risk factor for treatment, it can now be viewed as some protection from DEP, as the participants who were in the high PD group did not report clinical symptoms of DEP.

The view of PD as a protective factor is not to suggest that it is acceptable for African Americans to experience discrimination, but it is to acknowledge that discrimination is a common experience. Understanding that discrimination is a common experience for many African Americans and understanding that experience alone may send them to treatment may be the most effective way to provide them with good information about treatment for MDD. In essence, African Americans may be more open to discuss overcoming discrimination that can result in DEP than they may be at discussing DEP alone. The findings on avoidance subscale for NS and PD negate the fifth belief that African Americans avoid getting help. Whether African Americans believe

they are depressed or oppressed, they now are more willing to seek professional treatment.

Additionally, when African Americans experience poor psychological well-being, some may identify it as DEP and others as the result of PD. The overall findings suggest that the way African Americans view their psychological experience determines how they seek help. The direction of addressing PD in conjunction with education on MDD may be a promising way to reduce the preponderance of the disorder in the African American community.

The promise of combining the efforts of targeting PD and MDD in African Americans was well supported. As with the other IVs, I conducted correlational analysis to define the relationship between "willingness to see a doctor" (DV) and PD. The results suggested that there is a weak positive relationship between these two factors. The findings also indicated that PD influenced "willingness to see a doctor" more than SC, DEP, and symptoms. Like the findings on PD and OT, the positive relationship between PD and "willingness to see a doctor" suggested that African Americans might seek help when they feel mistreated or oppressed. These consistent findings warrant the need to discover if African Americans seek help only when they feel wronged or if they believe that they can trust a professional to help them only when they have been mistreated. In either case, there is a need to discover other factors related to PD that influence African Americans to seek OT and other professional mental health help. Determining these factors should enable mental health professionals to use the information to develop

programs and strategies to target these factors to encourage African Americans to seek mental health treatment before depressive symptoms are more difficult to treat.

Sociodemographic Factors

The null hypothesis for Research Question 2 was "The mean scores of NS and OT are equal across all the levels of SC, PD, and DEP when controlling for gender, income, education, and relationship status" (covariates). The null hypothesis was rejected, as the mean scores continued to vary as described in the sections on NS and OT when controlling for these covariates. The alternative hypothesis, "The mean scores of NS or OT differ across at least one of the levels of SC, PD, or DEP, when controlling for gender, income, education, and relationship status," was accepted.

The findings on the MANCOVA indicated that sociodemographic factors might not influence African Americans' SC, PD, and DEP. These findings further suggest that the results cited in the literature are mixed and that these factors contribute to an incomplete picture of mental health factors in African Americans. Ward et al. (2013) supported the position that gender does not play a role in DEP in African Americans; however, other literature suggested that African American men experience more depressive symptoms than women (Lincoln et al., 2012). Available literature also suggested that income and education were related to seeking treatment (Richman et al., 2007). The current findings provided evidence that contradicts the position that education and income influence OT. This contradiction may indicate that African Americans' experiences with discrimination because of their ethnic identity rather than their social and economic status motivate them to seek mental health treatment. Additionally, the

results of the MANCOVA did not support the assertion that relationship status influenced the DVs. However, it is important to note that having a limited or strained support system may impact the OT of African Americans given that their limited family support increases suicidality, and familial satisfaction influences well-being (see Lincoln et al., 2012; Lukachko et al., 2015). If African Americans lack family or friends to talk to, they may be more likely to seek outpatient mental health services.

Limitations of the Study

Of several possible limitations, one was participant attrition. The eligible sample was $N = 179$, but the actual sample was $N = 147$. The actual sample was also limited by some participants not completing all of the scales. The portion of the sample who did not complete all items could be representative of African Americans who have SC or DEP, or they could represent those who seek OT but are not open to sharing this information.

A second limitation was that sharing, and attrition may be related to privacy. Rather than being concerned about mental health stigma, potential participants may have been concerned with their personal information being seen on the internet. The survey was conducted online, and more than 70% of the sample heard about the study on social media. With the sensitive nature of the questions asked, participants may have felt uncomfortable disclosing this information on the internet. With computer hacking a global problem, potential participants may have felt that sharing this information on the internet could make them a target for scams, or that they simply did not want to potentially share something as intimate as their feeling about the topic.

Another limitation may have related to education. Ward et al. (2013) suggested that participants in their study may have been more open because of education, as most colleges provide counseling services, and many require students to take at least one psychology course. They suggested that having knowledge of mental health through a psychology course might increase African Americans' openness to sharing that information. Campbell and Long (2014) found that in spite of greater knowledge, some African Americans are less open because of mistrust of medical professionals. The results may be limited because I did not examine psychological openness. Considering this limitation, it should be noted that psychological openness may have been a factor in OT and NS, as more than 65% of the sample had an associate degree or higher, and nearly 90% had some college education. Psychological openness may not have been correctly measured in the study because there was some attrition, and some participants did not complete the entire survey.

Recommendations

The findings and limitations of this research establish groundwork for future studies on MDD in African Americans. More than 70% of the sample was derived from social media, and less than 5% of the sample heard about the study from an outpatient mental health clinic. Future researchers might focus on examining factors such as PD and SC in African Americans who are currently in OT. Learning and using the reasoning of African Americans who do use OT may be the best way to encourage other African Americans to seek treatment, as their positive experiences might encourage others to trust professionals. OT may include primary care treatment, given that Bailey et al. (2011)

indicated that some African Americans seek treatment for somatic symptoms in this setting.

Barnes et al. (2018) further supported the assertion that the population needs encouragement to trust medical and mental health professionals, as these researchers found that African Americans presented to their primary care doctors for chronic medical conditions and at least two symptoms of DEP, but their physicians never screened or provided treatment for DEP. It would be helpful to learn the reasons their physicians did not refer them to a mental health professional and to learn the barriers that had prevented those in treatment from seeking treatment in the past.

In addition to studying African Americans in OT, it is important to examine SC and self-disclosure in African Americans. Larson and Chastain (1990) showed that SC and self-disclosure are different but related constructs. Conducting research similar to the present study in which I investigated the effects of self-disclosure on African Americans' NS and OT could provide further insight into how to encourage nontreatment-seeking African Americans to seek OT and to seek it sooner, as earlier treatment might prevent more complex problems.

Future studies might involve more comprehensive approaches such as a mixed method design. Mixed method approaches might include focus groups, ethnological designs, and quasi-experiments. Ethnological designs would enable researchers to be a part of the African American experience, giving them a better way to accurately interpret research findings. Using focus groups along with quasi-experiments could help identify more factors that may increase the likelihood of African Americans seeking OT. Focus

groups might provide African Americans with greater knowledge of topics such as self-disclosure, SC, PD, DEP, and OT options to increase the likelihood that they would understand their experiences better.

Additional research might reveal whether there is a natural support system among participants and the strength of that system on factors such as SC and DEP. The impact of a limited support system, however, might prevent some African Americans from seeking help entirely since they are more prone to using NS (see Lincoln et al., 2012; Ward et al., 2013). Conversely, having a limited support system may compel some to seek professional treatment sooner (see Lincoln et al., 2012); however, a strong support system might also be a deterrent to seeking OT (see Lincoln et al., 2012). If a strong support system is a deterrent, efforts to teach family and social support systems about DEP and mental health treatment might be effective, as family members may encourage a depressed relative to seek needed treatment.

Implications

The results supported the concept that positive social change might result if treatment for MDD for African Americans can be generalized to the African American population, as the participants were a nonprobability sample self-selected through solicitation on social media and by word of mouth and included participants who were both depressed and not depressed. Because the findings showed that SC and PD impact how African Americans address their mental health, mental health professionals could use the findings to support their decisions to continue to encourage African Americans to accept treatment for DEP and other mental health problems. Researchers might also

develop and evaluate programs that address SC and PD in African Americans. Developing strategies to engage African Americans in virtual mental health options may be one way to help them seek treatment. African Americans may view virtual mental health options as convenient and fast but still distrust the treatment (George, Hamilton, & Baker, 2012). Virtual mental health or telehealth should be considered an option, since most participants used the internet, suggesting that African Americans may be willing to discuss mental health virtually.

These findings further imply the need to incorporate mental health interventions at the places African Americans currently seek help. Offering regular DEP screenings at churches and in primary care settings could be beneficial. Since African Americans have been shown to seek help from religious resources, it is possible that their pastors or churches with African American members could encourage African Americans to seek OT sooner by offering free DEP screenings at church (such as the PHQ-9) similar to the way free blood pressure screenings are offered. The screenings should be offered to all members regardless of ethnic background to normalize the experience and to encourage everyone to monitor their mental health. Screening all individuals promotes a positive attitude toward acknowledging that MDD is one of the largest psychologically disabling disorders in the United States and that seeking treatment for it is not an acknowledgement of personal weakness.

Finally, mental health professionals and researchers might develop mental health interventions to address the specific needs of African Americans. Because many African Americans are highly religious (Lukachko et al., 2015), interventions for DEP should

incorporate spiritual intervention when appropriate. Interventions for African Americans should also focus on the family system or natural support system, as these findings, like existing literature, continue to support the fact that African Americans prefer to seek help within them .

Conclusion

This study was a survey of factors that influence African Americans to seek or not seek treatment for MDD. The survey measured the influence of levels of SC, PD, and DEP on African Americans' use of their NS and use of OT. The results provided evidence that African Americans do not avoid OT but rather are more likely to seek OT when they have PD. The results further provided evidence that some African Americans may not experience depressive symptoms because they receive help from their NS, while others may be more likely to have SC.

One significance of this study is that mental health professionals and researchers could use the information to develop studies to understand other attributes that African Americans with PD have that cause them to avoid or seek treatment. Once identified, mental health professionals can provide education within the African American community about the impact on these factors on MDD and seeking mental health treatment. Finally, the overall significance of this study was that it provided an alternative view of African Americans' view of mental health, as many may seek treatment for PD that they perceive is needed. Future research and mental health interventions should focus on helping African Americans develop the propensity to seek OT specifically for MDD rather than only seeking treatment for PD.

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Appendix A: Permission To Use the SCS

From: Dale Larson
Sent: Wednesday, September 27, 2017 6:53:40 PM
To: Danita M. Morales Ramos
Subject: Re: Self-Concealment Scale

Danita--
You have my permission to use the scale. I am attaching relevant documents. Let me know how your research goes. Good luck!

Best, Dale Larson

Dale G. Larson, Ph.D.
Professor, Department of Counseling Psychology

Appendix B: Permission To Use the Brief Version of the PEDQ-CV

From: Elizabeth Brondolo
Sent: Friday, December 29, 2017 10:29:47 AM
To: Danita M. Morales Ramos
Subject: RE: Permission to use the Brief Version of the Perceived Ethnic Discrimination Questionnaire

Sure. You have permission. You may also find it helpful to include the past week scale as well. Good luck. Let me know what you find. - Liz

Appendix C: Permission To Use the PCS

From: Earlise Ward
Fri 1/5/2018 3:58 PM
To: Danita M. Morales Ramos
4 attachments (977 KB)
Coping Scale-Rev-Ward.pdf; COPING Scale-Scoring-Ward.pdf; Ward and Hiedrich-Beliefs-RNAH.pdf; Ward-Wiltshire-DeTry-Brown 2013.pdf;

Hello Danita,

I hope you are doing well, and the new year is off to a great start for you. You have my authorization to use the PCS, which is attached along with 2 manuscripts for citation purposes.
For use of the PCS, I do request that you provide me with study results (brief report), as I am interested in your important research. Also, and if possible might there by any opportunity to engage in manuscript writing and co-publication with you, I would certainly be interested.

Wishing you well.
Dr. Ward

Earlise C. Ward, PhD, LP Associate Professor School of Nursing

Appendix D: Participant Survey

A. Please select the appropriate box for each question:

1. Gender
   ☐Male
   ☐ Female
2. Age
   ☐18-20
   ☐21-29
   ☐30-39
   ☐40-49
   ☐50-50
   ☐60 or older
3. Please select the answer that is true to you.
   ☐ I have never lived in the United States
   ☐I have lived in the United States for at least 6 months
   ☐I currently live in the United States and have lived in the United States for at least 6 months
4. Relationship status
   ☐Single, never married
   ☐Married
   ☐In a Relationship
   ☐Divorced
   ☐Separated
   ☐Widowed
5. Education
   ☐Less than high school
   ☐High school graduate, diploma or the equivalent (for example: GED)
   ☐Some college credit, no degree
   ☐Trade/technical/vocational training
   ☐Associate degree
   ☐Bachelor's degree
   ☐Master's degree
   ☐Professional degree
   ☐Doctorate degree
6. Income
   ☐Less than $24,999
   ☐$25,000-$49,999
   ☐$50,000-$74,999

☐$75,000-$99,999
☐More than $100,000

7. Employment Status
   ☐Employed for wages
   ☐Self-employed
   ☐Out of work and looking for work
   ☐Out of work but not currently looking for work
   ☐A homemaker
   ☐A student
   ☐Military
   ☐Retired
   ☐Unable to work
8. Where you heard about the study
   - Outpatient Mental Health Clinic
   - Community Organization (e.g., chamber of commerce, human services, community service board)
   - Religious Organization (e.g., church, synagogue, chapel)
   - Social Media (e.g., Facebook, LinkedIn, Google+)
   - Collegiate Setting
   - Primary Care Setting

B. Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all – 0, Several days – 1, More than half the days – 2, Nearly every day - 3

1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thinking that you would be better off dead or				

that you want to hurt yourself in some way	0	1	2	3

B. If you selected any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All
Somewhat Difficult
Very Difficult
Extremely Difficult

C. During the past 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered at all	Bothered a little	Bothered a lot
1. Stomach pain	0	1	2
2. Back pain	0	1	2
3. Pain in your arms, legs, or joints			
4. (knees, hips, etc.)	0	1	
5. Menstrual cramps or other problems			
with your periods WOMEN ONLY	0	1	2
6. Headaches	0	1	2
7. Chest pain	0	1	2
8. Dizziness	0	1	2
9. Fainting spells	0	1	2
10. Feeling your heart pound or race	0	1	2
11. Shortness of breath	0	1	2
12. Pain or problems during sexual			
intercourse	0	1	2
13. Constipation, loose bowels, or diarrhea	0	1	2
14. Nausea, gas, or indigestion	0	1	2
15. Feeling tired or having low energy	0	1	2
16. Trouble sleeping	0	1	2

D. People differ a lot in the ways they cope with mental illness. If you had a mental illness or mental health problem what would you do? Please select from the choice that indicate what you would do.

	Definitely do this	Might do this	Not sure if I would do	Definitely not do this	N/A

			this		
1. See a medical doctor	4	3	2	1	0
2. Go to the emergency room	4	3	2	1	0
3. Go to a mental health therapist (psychologist, psychiatrist, social worker, or counselor)	4	3	2	1	0
4. Take medication	4	3	2	1	0
5. Go to my school counselor	4	3	2	1	0
6. Contact social services	4	3	2	1	0
7. Talk to my family	4	3	2	1	0
8. Talk to my friends	4	3	2	1	0
9. Ask people who have had similar experiences what they did	4	3	2	1	0
10. Try to get as much information as possible	4	3	2	1	0
11. Talk to my pastor or minister	4	3	2	1	0
12. Pray	4	3	2	1	0
13. Rely on faith	4	3	2	1	0
14. Try to handle it on my own	4	3	2	1	0
15. Try to ignore the problem	4	3	2	1	0
16. Do nothing	4	3	2	1	0
17. Use alcohol or other drugs to make myself feel better	4	3	2	1	0
18. Get upset and let my feelings out	4	3	2	1	0
19. Express my negative feelings	4	3	2	1	0

E. How comfortable would you feel talking about mental health problems with a professional?

Please select your choice

Very comfortable	Somewhat comfortable	Not very comfortable	Not at all
4	3	2	1

F. How embarrassed would you be if others knew you were getting professional help for a mental health problem? Please select your choice

Very embarrassed	Somewhat embarrassed	Not very embarrassed	Not at all
4	3	2	1

G. Think about your ethnicity/race. What group do you belong to? Do you think of yourself as: Asian? Black? Latino? White? Native American? American? Caribbean? Irish? Italian? Korean? Another group?

YOUR ETHNICITY/RACE: _____

H. How often have any of the things listed below happened to you, because of your ethnicity?

BECAUSE OF YOUR ETHNICITY/RACE …

How often…

	Never		Sometimes		Very Often
1. Have you been treated unfairly by teachers, principals, or other staff at school?	1	2	3	4	5
2. Have others thought you couldn't do things or handle a job?	1	2	3	4	5
3. Have others threatened to hurt you (ex: said they would hit you)?	1	2	3	4	5
4. Have others actually hurt you or tried to hurt you (ex: kicked or hit you)?	1	2	3	4	5
5. Have policemen or security officers been unfair to you?	1	2	3	4	5
6. Have others threatened to damage your property?	1	2	3	4	5
7. Have others actually damaged your property?	1	2	3	4	5
8. Have others made you feel like an outsider who doesn't fit in because of your dress, speech, or other characteristics related to your ethnicity?	1	2	3	4	5
9. Have you been treated unfairly by co-workers or classmates?	1	2	3	4	5
10. Have others hinted that you are dishonest or can't be trusted?	1	2	3	4	5
11. Have people been nice to you to your face, but said bad things about you behind your back?	1	2	3	4	5
12. Have people who speak a different language made you feel like an outsider?	1	2	3	4	5
13. Have others ignored you or not paid attention to you?	1	2	3	4	5
14. Has your boss or supervisor been unfair to you?	1	2	3	4	5
15. Have others hinted that you must not be clean?	1	2	3	4	5
16. Have people not trusted you?	1	2	3	4	5
17. Has it been hinted that you must be lazy?	1	2	3	4	5

I. Please indicate the extent of your agreement with each of the following statements using the scale below:

Strongly	Disagree	Neutral	Agree	Strongly

Agree Agree
1 2 3 4 5

Please select one number for each item.

1 2 3 4 5 I have an important secret that I haven't shared with anyone.
1 2 3 4 5 If I shared all my secrets with my friends, they'd like me less.
1 2 3 4 5 There are lots of things about me that I keep to myself.
1 2 3 4 5 Some of my secrets have really tormented me.
1 2 3 4 5 When something bad happens to me, I tend to keep it to myself.
1 2 3 4 5 I'm often afraid I'll reveal something I don't want to.
1 2 3 4 5 Telling a secret often backfires and I wish I hadn't told it.
1 2 3 4 5 I have a secret that is so private I would lie if anybody asked me about it.
1 2 3 4 5 My secrets are too embarrassing to share with others.
1 2 3 4 5 I have negative thoughts about myself that I never share with anyone.

Appendix E: Letter of Cooperation From Research Partner

Genesis Counseling Center
Dr. Trina Young Greer, Executive Director

August 23, 2018

Dear Danita Morales Ramos,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Self-concealment, Perceived Discrimination, and African Americans' Treatment Choices for Major Depression at Genesis Counseling Center. As part of this study, I authorize you to distribute flyers and email notifications about the study at the agency to solicit your colleagues (i.e., therapists, clinicians, psychologists) to share the study with individuals that may be interested in the study. Individual participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include allowing you to advertise about the study through word-of-mouth with your colleagues at any of Genesis Counseling Center sites. We reserve the right to withdraw from the study at any time if our circumstances change.

I understand that the student will not be naming our organization in the doctoral project report that is published in ProQuest.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Authorization Official

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature"

can be the person's typed name, their email address, or any other identifying marker. Walden University staff verifies any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).