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# The Main Sociocultural predictors of Mental Health Disparities among Older, African American Women

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**Abstract**

*This study examines sociocultural predictors of mental health disparities among older, African American Women. The current study investigated how the sociocultural factors of ethnicity, mental health beliefs, ethnic identity, age, spirituality, and religiosity predicted utilization of formal and informal mental health treatment services. Furthermore, this study discusses the existing literature regarding theories, risk and protective factors, and relevant prevention and intervention responses in relation to depression among older African American women. Although there is an abundance of research on depression, most of the research study literature tends to relate to other cultures. Subsequently, the relevant literature shows there is a limited amount of information focusing on older African American women and their experiences with depression. The current study suggests that attitudes and beliefs about mental illness and health practices is a factor that should been considered by clinicians when assessing, diagnosing, treating and trying to maintain adherence to services of older African American Women.*

***Keywords:*** depression**,** elderly, treatment, support**,** women and research.

## 1.1. Introduction

Depression among elders is one of the most common and significant mental health issues among people around the world (American Psychiatric Association, 2013; Givens, Katz, Bellamy, & Holmes, 2007; Li, Pang, Chen, Song, Zhang, & Zheng 2011; Schulman, Sirey, Bruce, & Alexopoulos, 2005; Zalaquett & Stens, 2006), yet it is often seen as inevitable, specifically among older adults of color (Sriwattanakomen, McPherron, Chatman, Morse, Martire, Karp.,…Reynolds 2010; Zalaquett & Stens, 2006). Although there is an abundance of research on depression, most of the research tends to relate to other cultures. Subsequently, research has shown there is a limited amount of information focusing on older African American women and their experiences with depression. The term 'African American' describes people of African descent living in the United States which encompasses a complex, multidimensional population that includes a variety of subpopulations (Bailly, & Roussiau, 2010). Although there are important commonalities among African Americans, ethnicity is a neglected dimension of the heterogeneity of this segment of the population (Bailly, & Roussiau, 2010; Li, et al., 2011; Sriwattanakomen, et al., 2010).

This study highlights the importance of ethnicity as it pertains to the use of mental health services among the older African American female population. This study also explores the relationship between ethnicity, gender, religious beliefs and mental health. It is noteworthy, there are no extant studies examining predictors of mental health treatment utilization that have distinguished ethnicities and gender within the older African American population. Research among older Angle Americans has demonstrated the importance of socio-cultural variables, such as ethnic identity (Yasui, Dorham, & Dishion, 2004), mental health beliefs and religiosity in accounting for different rates of mental health treatment. However, the relationship between socio-cultural factors and mental health treatment has not been examined in older African American females. To address this shortcoming this study examined the existing literature regarding theories, risk and protective factors relevant prevention and intervention in relation to depression among older African American women. Related theories include social construction and intersectionality. Risk and protective factors include age, social support, religion, caregiving, and physical health (Li, et al., 2011; Sriwattanakomen, et al., 2010).

### 2.1. Literature Review

It is well documented in the relevant literature that older African American adults experience more stressful life events, economic hardships, and are exposed to more trauma-related experiences than any other ethnicity in the United States (American Psychiatric Association, 2013; Lo, Lin, Gagliese, Zimmermann, Mikulincer, & Rodin, 2010). In contrast to normative stressful life events (e.g.,financial problems), major traumatic events, such as rape and war, are unanticipated and uncontrollable (Lo, et al., 2010). Furthermore, the studies of Petkus, Gum, King-Kallimanis, and Wetherell (2009) indicated that, unlike Anglo Americans, older African American women tend to experience multiple traumatic events in their lifetime. Nevertheless, there are very few studies that examine the impact of traumatic events throughout African American females' lifetime, and especially lacking are studies of the effects of trauma on mental illness and seeking treatment services among older African American females.

The few extant studies focusing on the effects of traumatic events on older African American females (e.g., Petkus et al., 2009; Sriwattanakomen, et al., 2010) revealed that the high frequency of traumatic event during one's lifetime is a significant predicting factor for declines in physical and cognitive functioning. In addition, exposure to trauma can often increase the likelihood of depression and anxiety disorders (Cohen, Maggai, Yaffee, & Walcott-Brown, 2005). Both disorders are a serious concern among older African American female population.

Furthermore, Byers, Yaffe, Cowinskiy, Friedman, & Bruce, (2010) assert that anxiety is one of the most common mental disorders among the older African American female population. Yet, few studies have examined anxiety disorders among older African American females. Anxiety is a risk factor for decreased adaptive functioning and poor health outcomes. Co-occurring anxiety and mood disorders exacerbate cognitive and medical disorders in older females (Cohen, Maggai, Yaffee, Walcott-Brown, 2006). Furthermore, Anxiety and depression are often significantly correlated. In fact, the studies of Cohen, Maggai, Yaffee, and Walcott-Brown (2005) found that older African American females are at risk for experiencing severe levels of depression. Depression is a risk factor for the onset and progression of mental medical and illnesses (Hunn, & Craig, 2009; Johnson, Tulsky, Hays, Arnold, Olsen, Lindquist, & Steinhauser, 2011).

Depression has been shown to increase the risk for cardiovascular disease (Egede, Nietert, & Zheng, 2005) congestive heart failure, hypertension, and coronary heart disease among African American older females adults. It is noteworthy that in spite of the high risk for experiencing trauma and mental illnesses, older African American females tend not to seek mental health treatment services after experiencing a traumatic event (Petkus, Gum, King-Kallimanis, & Wetherell, 2009), nor in the face of depression and anxiety disorders (Cohen et al., 2005). Overall, older African American females with depression and anxiety disorders underutilize mental health treatment services compared with White older females (Cohen et al., 2005; Hunn, & Craig, 2009).

Researchers have found that systemic factors, such as availability of health care services such as lack of insurance, cultural insensitivity , and poor detection ability by providers with regards to diagnosing African American females, often create barriers to mental health access (Petkus et al., 2009; Strothers, Rust, Minor, Fresh, Druss, & Satcher, 2005). Furthermore, the studies of Taylor, Chatters, and Jackson (2007) indicated that African American older adults may utilize alternative help seeking methods, such as religious coping and talking to family.

There are many gaps in the current research study literature regarding mental health disparities driven by anxiety and depression. One of the main gaps is that although anxiety and depression can affect anyone regardless of income, the focus tends to be on those who are on a limited income. Focusing on older women in communities who are a part of the middle and upper class would allow those who think depression is a poor person's illness to view it from a different perspective. Another gap is that most of the research available for this population tends to be cross-sectional, as opposed to longitudinal (Petkus et al., 2009). It is advantageous to analyze the effect that time has on older African American health outcomes (Egede, Nietert, & Zheng, 2005; Hunn, & Craig, 2009).

By measuring longer durations and at multiple time points, the changes in mean health status and the factors related to these health changes may become more evident (Hunn, & Craig, 2009). Furthermore, more recent data should be used to study the mental health disparities among this population. Finally, more detailed studies of social group variation in depression trajectories and how age ties into patterns of depression across genders and races are gaps that need more attention (Otubanjo, & Bergstresser, 2008).

Future research may benefit from using more mixed methods approaches to understanding how older adults see loneliness and depression. Stigma has played and continues to play a major part in the treatment of mental illness. The types of treatment for depression has varying levels of stigma attached to it, whether it is for mental health counseling, antidepressants, or complementary and alternative medicines (CAM). Raising awareness about depression and mental illness, in general, can help to decrease the effects of stigma on those suffering with depression, no longer keeping it a secret from others, but putting it out there in the light so that those suffering from it can know that they are not alone, it is common, it is real, and it is not a part of aging. Ultimately, raising awareness about mental illness driven by anxiety and depression can improve treatment by allowing those with a history of mental illness to share coping skills and mechanisms, bringing attention to the cause.

### 3.1. Theoretical Framework

Throughout the relevant literature, several theoretical perspectives are used to analyze the problem of mental health disparities among older, African American women, including the life course perspective, psychology of religion, stress and coping model, and social cognitive theory. More than one theory is often used concurrently to examine mental health disparities driven by depression among African Americans (Hunn, & Craig, 2009). Given their unique history in the United States and their continued plight and circumstances, it is important to look at older African American women from varying perspectives. The major theoretical perspectives that will be used to guide this study will be social construction theory and intersectionality. These perspectives do not entirely explain depression among older African American women; however, they do offer an overarching framework for better understanding the factors connected to depression within this group (American Psychiatric Association, 2013; Hunn, & Craig, 2009).

The theory of social construction is used primarily in the social sciences and humanities disciplines but has been adopted by other disciplines, such as business studies, as well (Otubanjo, 2012). Berger and Luckmann introduced the term "social construction" in 1966 as a means to describe the way in which individuals and groups construct their own realities given their social, cultural, and historical contexts (Otubanjo, 2012). They observed that all knowledge and understanding of the world comes from social interactions, as opposed to reasoning and experimentation (Otubanjo, 2012; Payne, 2005). The social construction theory seeks to examine how social phenomena and trends develop into customs and beliefs about the changing processes within the society (Otubanjo, 2012). This interpretivist postmodernist theory, along with reflective and intentional theories, is a part of cultural representation theories and is linked to social psychology and social constructivist theory (Otubanjo, 2012; Payne, 2005).

Social workers use the social construction theory as a basis for psychotherapy (Payne, 2005). In practice, social construction models respond specifically to clients' own views of their world and assessment of their problems (Payne, 2005). In research, human interactions, such as conversations, are systematically analyzed, often using video- and audio-taped recordings of interactions (Payne, 2005). These analyses help to reveal communication and behavior patterns that may be hidden (Payne, 2005). Rooted in Black feminist scholarship, intersectionality is similar to the cumulative advantage/disadvantage theory, cumulative inequality theory, and the double/triple jeopardies perspectives (Bowleg, 2012; Mair, 2010; Spence et al., 2011), which are also referred to in the literature as multiple-stratification or multiple-hierarchy stratification perspectives (Rozario, Chadiha, Proctor, and Morrow-Howell, 2008; Sriwattanakomen, et al., 2010)

Although some scholars call it a theory or approach (Walby, Armstrong, & Strid, 2012; Warner & Brown, 2011), others refer to intersectionality as a unifying, interpretive, theoretical framework or perspective (Bowleg, 2012). Bowleg (2012) stated that intersectionality is not a traditional theory in that it does not have any basic principles or variables that can be measured operationally or empirically tested. It is more of an analytical framework or paradigm. Although previous studies using intersectionality have been for mainly qualitative research, it is also important for quantitative research to take this approach into account (Warner & Brown, 2011).

The term "intersectionality" was first coined by feminist legal scholar Kimberle Crenshaw during the 1990s (Bowleg, 2012). However, the idea has been around for more than a century. Abolitionist Sojourner Truth challenged the idea of viewing the social constructs of gender and race separately in her famous "Ain't I a Woman?" speech at the 1851 Women's Convention in Akron, Ohio (Bowleg, 2012). It illustrated how African American women have often had to choose between their rights as African Americans and their rights as women. Not having to choose one identity over another is crucial, as it is impossible for one to just be seen as an African American without the gender aspect and vice versa. Crenshaw also used the term to explain the exclusion of Black women from feminist discourse, which centers around White women, and antiracist discourse, which centers around Black men (Bowleg, 2012). Intersectionality is also used to examine the multiple, interlocking influences of various systems of oppression and privilege such as, sexism, racism, and ageism (Bowleg, 2012).

Social construction and intersectionality are complementary frameworks. The social constructionist theory views experiences, such as depression, as culturally and socially constructed (Black et al., 2011). Depression develops in a particular context, as opposed to developing independent of one's experience (Black et al., 2011; Black & Rubinstein, 2009; Black et al., 2007). Older adults are seen as the active creators of their own unique worlds and as the experts in explaining those worlds to other individuals (Black et al., 2011). Furthermore, the intersectionality perspective in aging research, especially quantitative aging research, is scarce, yet offers the ideal foundation for exploring the effect of various risk and protective factors on depression for African American women (Mair, 2010). As older African American women, the concept of depression varies by not only race/ethnicity, but also by gender and one's experiences of it. Adding age into the component makes for a more in-depth perspective, since older African American women are often seen as society's least privileged group in terms of socioeconomic status and health (Black et al., 2007; Hunn & Craig, 2009).

### 4.1. Risk and Protective Factors

When examining risk and protective factors, it is also important to know what kinds of models have emerged in the research. The risk-focused and protective-focused models developed by Hawkins, Catalano, and Miller in 1992 have been used many times over the past few decades as the foundation for observing and investigating health outcomes in different populations (Li, et al., 2011). They address factors that both increase and decrease risk of various diseases (Li, et al., 2011). Risks can be described as hazards in the individual's surroundings that may led to a greater likelihood of a problem arising (Sriwattanakomen, et al. 2010). Protective factors refer to the safeguards in the individual's environment that improve one's ability to resist problems and to cope with life stressors (Lo, et al., 2010). Statistically speaking, risk processes are known as main effects and protective processes denote interactions (Li, et al., 2011; Sriwattanakomen, et al. 2010). While each individual model has its pros and cons, combining the models helps to increase validity and more fully capture the reality of the population (Li, et al., 2011; Lo, et al., 2010).

Rozario, et al. (2008) stated that the contextual complexity of African American women's lives put them at risk for developing depression, given their multiple roles in their families and society. Lazear, Pires, Isaacs, Chaulk, and Huang, (2008) reported that lower incomes and greater financial strain, greater caregiving burden, and poorer health status also play roles in their risk for depression. Other risk factors that emerged in the literature were minority racial status, being female, living in poverty, being uninsured, receiving public medical benefits, low socioeconomic status, lower education, being less religious, obesity, lower social support, poorer satisfaction with support, greater functional disability and health limitations, of advanced age, lower sense of mastery, and unmarried status (Frank Matza, Revicki, & Chung, 2005; Li et al., 2011; Sriwattanakomen, et al. 2010). The proposed risk and protective factors for depression that will be focused on in this study are age, social support, religion, caregiving, and physical health.

**5.1. Age**

Although depression is thought to be a part of the aging process, it is not preordained. Warner, and Brown (2011) found that age was inversely associated with depression, taking into account spiritual well-being and attachment security in metastatic cancer patients. Spiritual well-being was defined as the ability to see one's life as meaningful and purposeful, while attachment security was the sense that social support will be available if needed. Having these two resources, described as adaptive capacities, allowed older patients to better cope with their diseases. Using the adult attachment theory as a framework, the study focused on whether age-related patterns in attachment security and spiritual well-being accounted for the protective effect of age against distress.

A quantitative study conducted by Lo et al. (2010) assessed levels of depression, attachment security, spiritual well-being and disease burden were operationalized, with attachment security and spiritual well-being, as mediators of the effect of age on depression, controlling for disease burden. While age was found to be inversely associated with depression, depression was found to be inversely associated with attachment security and spiritual well-being. Furthermore, their findings suggested that age is positively associated with spiritual well-being and attachment security, and the effect of age on depression is mediated by the two coping mechanisms. It was concluded that protection from psychological distress among older cancer patients may be indicative of age-related developmental achievements and/or differences in responses to adverse events in life.

**6.1. Socio-cultural Characteristics**

Culture plays a huge role in geriatric depression (Li et al., 2011). Its conceptualization and perception vary by culture (Frank et al., 2005; Martin, 2009; Pedraza, Dotson, Willis, Graff-Radford, & Lucas, 2009) and is viewed as a cultural phenomenon and lived experience (Black et al., 2007). To some immigrants, depression may be a sign of homesickness (Lazear et al., 2008). To other populations, depression may be associated with having the blues, experiencing sadness, feeling down, and being tired or sleepy (Lazear et al., 2008). Still, some see it as a personal weakness (Jang, Borenstein, Chiriboga, & Mortimer, 2005), a "crisis of the spirit" (Black et al., 2011), and a "weakness of the lowest kind" (Beauboeuf-Lafontant, 2008). To some African American women, depression may be a "feminine, middle-class, white women's" issue (Black et al., 2007). Various health care professionals also understand depression differently based on their fields of study and backgrounds (Black et al., 2011). Studies have shown that depression among older African Americans is becoming more and more likely to be understood as a result of their past and continued marginalization in this country (Black et al., 2011). In addition, researchers are just beginning to recognize and explore different clinical strategies that keep in mind the cultural and social differences of African American women (Hunn & Craig, 2009).

Waite and Killian (2008) completed a qualitative study exploring the health beliefs related to depression among African American women who had been clinically diagnosed with major depression and had received treatment for it. A purposeful sample of 14 self-identified African American women was chosen to conduct focus group interviews. Using the core constructs from the Health Belief Model, they classified participants' beliefs into five major content areas: (a) perceived susceptibility to depression, (b) perceived severity of depression, (c) perceived benefits of treating depression, (d) perceived barriers to treatment, and (e) cues to action. Most women in the study did not believe they were at risk for becoming depressed and believed that the level of severity was based on how she perceived life's circumstances. The benefits of treating depression were related to the severity level, when depression was acknowledged, and barriers included stigma, denial about having depression, limited knowledge about depression, reluctance to take any medication for it, and lack of finances for treatment. Cues to take action against depression were stated to be initiated from family, friends, the community, religious leaders, and the media. The study implied that in order to build treatment alliances that are effective, clinicians must better understand clients' views of depression.

Among older African American women, depression has been linked to sadness and suffering, the diminishment of personal strength, and seen as preventable or resolvable through one's own capabilities (Black et al., 2007). Barg, Huss-Ashmore, Wittink, Murray, Bogner, and Gallo (2006) used a purposive sample of 102 older adults with and without significant depressive symptoms, based on participants' scores from the Center for Epidemiologic Studies-Depression scale (CES-D), to describe what loneliness and depression meant to them. A mixed-methods approach was used for the study. Recruited from primary care facilities, participants were interviewed in their homes. Descriptors of depression included lonely, lack of interest, down, sad, and not talkative.

The terms participants used to describe themselves when depressed were sad, lonely, tired, anxious, depressed, and physical pain. Loneliness was the most salient term on both lists and was seen as a precursor to depression, as self-imposed withdrawal, or an expectation of aging. It was also highly correlated with hopelessness, anxiety, and depressive symptoms (Gilbert, Harvey, & Belgrave, 2009).

The stigma of depression and mental illness, in general, is a major factor (Min, 2005; Nadeem, Lange, Edge, Fongwa, Belin, & Miranda, 2007). Depressed individuals reportedly view depression as more stigmatized than non-depressed people (Nadeem et al., 2007). Furthermore, the stigma of depression and other mental health illnesses may be higher among African Americans when compared with Whites (Givens, Katz, Bellamy, & Holmes, 2007). African American women are seen as and are socialized to use the "John Henryism" (Hunn & Craig, 2009). As legend has it, John Henry, a folk hero and slave, died trying to outwork a machine. The John Henryism is, as a result, a prolonged high-effort coping mechanism to help overcome various challenges through hard work and dedication, without regard to one's own mental and physical health (Hunn & Craig, 2009). It is assurance that whatever needs to be done, gets done (Dilworth-Anderson, Goodwin, & Williams, 2004). Hunn and Craig (2009) reported that only about 17% of African Americans report difficult and stressful encounters or depressive symptoms due to the need for them to be independent and in control of situations, as the John Henry syndrome illustrates.

An African American woman admittedly suffering from depression goes against those beliefs, as Beauboeuf-Lafontant (2005) describes, with the image of the "strong Black woman" coming to the forefront, influenced by a history of surviving and overcoming such challenges as racism, violence, and social contextual injustice (Nicolaidis, Timmons, Thomas,Waters, Wahab, Mejia, & Mitchell, 2010). The African American woman is seen as being able to take care of everyone else first and taking care of herself last, if at all (Beauboeuf-Lafontant, 2005). Schieman and Plickert (2007) call older African Americans the "survival elite," when compared with younger African Americans. Older African American women are also seen as the matriarchal figures in African American culture, which Beauboeuf-Lafontant (2005) refers to as "mules of the world." This "other mothering" sees the role of older African American women as community mothers in hostile political and economic surroundings (Gibson, 2005). As is the case, her fears, desires, and struggles are often silenced and go unnoticed and unappreciated (Beauboeuf-Lafontant, 2008). Nevertheless, there is the history of racism tied with sexism that sometimes is brought about from their male counterparts. These –isms, along with others, are often only acknowledged when it harms the dominant culture (Gilbert, et al., 2009).

### 7.1. Comparison of Gender and Race

Among a sample of 72 black and 143 white participants in a randomized clinical trial of indicated depression prevention in later life, Sriwattanakomen et al. (2010) found higher frequencies of eight risk factors for depression and a higher mean number of risk factors among Blacks than Whites. Black participants were more likely than White participants to (a) have fewer years of education, (b) lower household income, (c) be obese, (d) live alone, (e) experience functional disability, (f) have a history of alcohol and drug abuse, and (g) have lower scores on the Mini-Mental State Examination and the Executive Interview (EXIT). White participants were found to have lower prevalence and mean scores on any given risk factor. They also experienced about one less risk factor than Black participants.

Steffens, Fisher, Langa, Potter, & Plassman (2009) found similar rates of depression for males and females among their Aging, Demographics, and Memory Study (ADAMS) sample. Drawn from the larger Health and Retirement Study, the ADAMS sample consisted of a total of 851 participants age 71 and older. Each participant had available depression data, which had been measured using the Composite International Diagnostic Interview – Short Form (CIDI-SF) and the Neuropsychiatric Inventory's (NPI) informant depression section. The national prevalence of depression was estimated and stratified by race, age, sex, and cognitive status using logistic regression analyses. An overall prevalence rate of 11.19% when combining symptoms of major or minor depression and reported treatment was found, with 10.19% for men and 11.44% for women. The prevalence rates of Whites and Hispanics were about three times higher than those of African Americans. Higher depression rates were associated with dementia diagnosis and pain severity in general, while Black race was associated with lower depression rates. The similar depression rates for men and women were said to be due to the population's representativeness of racial, ethnic, and socioeconomic diversity.

Ghods, Roter, Ford, Larson, Arbelaez, & Cooper (2008) found no racial differences in the level of depressive symptoms comparing 108 African Americans and Whites receiving care from 54 physicians in urban community-based practices. The study was a cross-sectional study of primary care visits with 62 African American patients and 46 White patients experiencing depressive symptoms as measured by the Medical Outcomes Study-Short Form (SF-12) Mental Component Summary Score. The study found that African Americans in the sample had less education and reported poorer physical health when compared with White patients. However, no racial differences were found in the level of depressive symptoms. Only 34% of the visits included depression communication, with the average number of depression-related statements being much higher in the White patient visits than the African American patient visits. Additional results included less rapport building with African American patients, African Americans were more likely to be rated in fair or poor physical health, and a lower percentage of African Americans than Whites were considered to have significant emotional distress, even in visits where depression was inquired. The study recommends that, due to racial disparities in communication among primary care patients with a high level of depressive symptoms, there needs to be more physician communication skills training programs, with an emphasis on recognition and rapport building, to reduce racial disparities in depression care.

Furthermore, Mills, Alea, and Cheong (2004) found no racial/ethnic differences in the mean level of depressive symptoms, which were revealed through descriptive and multivariate analyses. Some studies have suggested that older African Americans are more susceptible to depression than older whites, while other studies say whites have higher depression rates, and others state there are no racial differences (Pedraza et al., 2009). The variation in the results of these studies could be due to differences in age range and composition of the samples, research settings, and assessment tools (Jang, Borenstein, Chiriboga, & Mortimer, 2005). Additionally, depressive symptoms among these groups are complex and ambiguous, and racial differences are said to increase slightly over time (Spence, Adkins, & Dupre, 2011).

Although there have been many studies comparing older Black and White populations, the focus of this study will specifically be on the factors of older, community-dwelling, African American women experiencing bouts with depression, who either have been clinically diagnosed without pharmaceutical treatment, self-diagnosed, or have been diagnosed by a doctor and taking medications (Bazargan, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2005).

**8.1. Social Support**

A common source of strength among older African American women is a social support network, which includes family, neighbors, and those who are involved in senior centers. Family members help older adults to lessen depressive symptoms through visits, travels, and care. Knowing that people care helps as a coping mechanism. Neighborhoods are also considered a supportive ethnic enclave among African Americans and may assist with the mental and emotional health of residents due to shared language and customs, the provision of mutual aid, and identification with others of similar backgrounds, thus promoting social cohesion (Aneshensel, Wight, Miller-Martinez, Botticello, Karlamangla, & Seeman, 2007). Often, older adults will also cope by attending senior centers to take their minds off of mental stressors, current realities, and the past. Associating with other seniors helps them to see that their circumstances may not be as bad as they think. Social support is a coping resource that also helps to prevent functional decline, thus allowing an elder to remain in a community setting (Jang et al., 2005). Having larger social networks, as well as certain types of social networks, is connected to positive intervening effects on depression (Mills et al., 2004). For instance, while instrumental support is associated with higher levels of depressive symptoms, higher levels of emotional support and having several close relationships is associated with a positive direct effect on levels of depression (Mills et al., 2004).

**9.1. Religiosity/Spirituality**

An undisputable method for alleviating depression for many older African American women is religion and spirituality (Jang et al., 2005), which can be seen as the same or different entities, depending on who is asked. Viewed as one of the most spiritually connected groups of people, with about 70% of African Americans attending a place of worship at least twice a month (Black, Gitlin, & Burke, 2011), many older African American women have used and continue to use their faith in a Higher Power to make it through illnesses and ailments of their minds and bodies. Religiosity and spirituality are often related to older African American women's lower rate of suicide, as well as their lower levels of suicide acceptability (Kaslow, Price, Wyckoff, Grall, Sherry, & Young, 2004). Clergy are sought out to counsel different people in the church and the community.

Clergy is seen as an informal type of help for mental health issues. Older African American women tend to seek the help of primary care providers, as opposed to specialty mental health providers, but they are less likely to be diagnosed as depressed among primary care providers (Barg et al., 2006). Interestingly, if one were to require more advanced services, this may be seen as a sign of weakness or a loss of or decrease in faith, rather than the problem being more severe than a leader in the church can address. It is important that those who do seek help within a church setting have qualified professionals within that setting or at least those who can adequately refer an individual to a trained mental health professional, if the need arises (Jang et al., 2005; Lowis, Edwards, & Burton, 2009).

In order for clinicians to better understand the lack of trust and treatment among the African American community, they must seek to include the African American church as a resource for better understanding the African American community's needs and strengths (& Craig, 2009). The African American church has been and continues to be a main source of spirituality, social support, and connectedness for this population, which has been documented in the areas of community medicine, disease prevention, health promotion, and community mental health (Hunn & Craig, 2009; Mills et al., 2004). During the mid-eighteenth century, the African American church was first created as an underground meeting of slaves. For more than a century, slaves gathered together to express their religious culture that resembled, but did not replicate, the Christianity of their White slave masters and families. The church became a place of refuge from the horrors of slavery, while instilling dignity and self-esteem in the slaves.

Following slavery and up through the Civil Rights Movement of the twentieth century, the African American church was also a safe haven from the effects of Jim Crow laws and was a meeting place for fighting systematic discrimination. Additionally, it was a pacesetter for the freedom and liberation movement. Given the African American church's illustrious history, it continues to be an informal social service provider and a mainstay in the spiritual, social, economic, political, and psychological preservation of African Americans (Mills et al., 2004). As the church is such a huge part of the African American culture, the African American church is a major mental health resource in the U.S. and should not be overlooked when addressing approaches to treatment for depression and other mental illnesses. The relationship between religiosity and depressive symptoms in African Americans is mediated through perceived support from the church (Hunn & Craig, 2009).

Many studies have shown that there is a positive link between religiosity/spirituality and wellness, and that religiosity/spirituality can be used in the clinical setting to help with solutions to problems (Allen, Phillips, Roff, Cavanaugh, & Day, 2008; Bailly & Roussiau, 2010; Hodge & Limb, 2010; Johnson et al., 2011). Spirituality may reduce the number of stressors in one's life, can be a coping mechanism that helps to create a sense of meaning in life, and helps to develop psychological resources, like self-esteem and a sense of personal worth among a network of like-minded people (Allen et al., 2008). Spirituality may also be more closely related to psychological well-being among elders more so than younger people due to significant life events, such as acute and chronic physical health issues, the loss of loved ones, and the approaching of one's own death.

For generations, African Americans have used spirituality to confront challenges such as oppression, poverty, and discrimination (Washington, Moxley, Garriott, & Weinberger, 2009). A lack of faith is associated with more depressive symptoms (Coleman, McKiernan, Mills, & Speck, 2007). Given these circumstances, clinicians must acknowledge one's religious or spiritual background and realize the power that prayer, worship, and other spiritual or religious activities can have in one's life during a crisis like depression (Black et al., 2011). Jang et al. (2005) stated that having positive coping resources are essential when facing stressful events in life. Both of the aforementioned resources are related to having better mental health and more successful efforts in coping with stressful situations (Jang et al., 2005).

Besides religious/spiritual activities and other forms of social support, a sense of mastery or control over one's environment and life is seen as an additional coping resource that has an effect on psychosocial health. Research has shown that having a sense of mastery is beneficial as it is indicative of psychological resilience that can help with adjusting to changes, overcoming obstacles and challenges, and promoting physical and mental well-being. However, it can also have the opposite effect and become a part of their John Henryism, as it is associated with poor health outcomes.

Wittink, Joo, Lewis, and Barg (2009) argued that older African Americans were less likely to be identified as depressed and less likely to be prescribed medications for depression. In their cross-sectional qualitative interview study, 47 older African American primary care patients were recruited from Baltimore, MD. A 60-minute semi-structured interview was conducted in each participant's home. Transcriptions of interviews were completed and spirituality themes as they related to discussing depression were identified using a grounded theory approach. Using a faith-based explanatory model of depression with an emphasis on the cause of depression and what to do about it, depression was seen as a loss of faith, that "getting faith" was the cure and the foundation for healing, and that religious activities, such as praying, talking to the pastor, and going to church, were used for coping with depression. This study stressed the importance of addressing a patient's spirituality in the clinical encounter, which could lead to improved detection for depression, as well as treatments that are more in line with patient's belief system.

### 10.1. Caregiving

Since social support is a large part of the African American community, older African American women are stepping in as grandmothers helping to raise their grandchildren, also called kinship care (Musil, Warner, Zauszniewski, Jeanblanc, & Kercher, 2006). Kinship care is viewed as a strength among African American families. Kinship care may take place with parents present or absent, known as co-parenting grandmothers or custodial grandmothers, respectively (Patel, Salahuddin, & O'Brien, 2008). Although there has been an increase in the number of grandparents raising grandchildren overall, African American grandmothers are more likely to participate in kinship care than grandmothers of other races (Lipscomb, 2005; Ruiz & Zhu, 2004). Kinship care often comes about as a result of family crises, such as parental drug use, unemployment, teen pregnancy, incarceration, HIV/AIDS, divorce, abuse and neglect, abandonment, or death (Ruiz & Zhu, 2004). In their other mothering roles, older African American women may also take on caring for other blood relatives and "fictive kin," those with no biological relationship (Blustein, Chan, & Guanais, 2004; Lipscomb, 2005).

Besides helping to raise their grandchildren, older African American women may have additional responsibilities and demands, including working in the labor force and caring for their own children, parents, and/or spouses (Engstrom, 2008). Given that the role of caregiving tends to place a tremendous amount of burdens and blessings on an individual, grandparents raising grandchildren tend to have poorer health outcomes when compared to non-caregivers (Baker & Silverstein, 2008a). Not only do these caregivers experience more health problems, they also may experience higher rates of depression due to low family cohesion and intergenerational conflict (Musil, et al, 2006; Patel, et al., 2008).

### 11.1. Physical Health

The indirect and direct costs of depression are extremely expensive (Zalaquett & Stens, 2006). Since 1987, depression has been one of the top disorders that has accounted for about half of the increase in health care spending (Zalaquett & Stens, 2006). It is estimated to cost the United States about $43-$44 billion each year, which is similar to the expenses related to coronary heart disease (Spence et al., 2011; Zalaquett & Stens, 2006). Additionally, it raises the total health care costs of depressed older adults by 50% (Spence et al., 2011). The costs of antidepressants are in the billions of dollars, while about $12 billion in labor is lost to depression yearly (Strothers, et al, 2005).

Not only is depression disabling financially, but also physically (Strothers, et al, 2005). It is a risk factor for diseases like diabetes (Bogner, Morales, Post, & Bruce, 2007) and is common among those with illnesses, such as impaired function, cancer, Congestive Heart Failure (CHF), medical morbidity and mortality, anxiety, incident dementia, Chronic Obstructive Pulmonary Disease (COPD), and other chronic health conditions (Johnson et al., 2011; Kelley-Moore & Ferraro, 2005; Steffens et al., 2009). Although most research is tailored to physical health disparities, as opposed to mental health disparities, the physical and mental aspects of health are often difficult to examine as separate entities (Spence et al., 2011; Jang et al., 2005). Depression and physical disability are highly correlated and may, over time, intensify one another (Kelley-Moore & Ferraro, 2005). Screening for depression is key, as depression can affect the diagnosis and treatment of various psychiatric and physical health issues, an older adult's functioning, and their quality of life (Lach, Chang, & Edwards, 2010).

### 12.1. Implication for Practice

It has been well documented in the research study literature there are striking disparities in mental health care for older racial and ethnic minorities involving access, appropriateness, quality, and outcomes (U.S. Department of Health and Human Services (2018). Disproportionate numbers of older African American females are represented in the most vulnerable segments of the population (e.g., victims of trauma, incarceration), have an increased risk for mental disorders, and are sadly not accessing appropriate mental health services. Previous research indicates that older African American females with depression and anxiety disorders underutilize mental health treatment services compared with White older adults (Cohen et al., 2005). Studies (e.g., Black, White, & Hannum, 2005; Taylor, Chatters, & Jackson, 2007) also indicate that Black older adults may utilize alternative help seeking methods, such as religious coping and talking to family. This study confirms that older African American females' underutilization of mental health services may be due not only to preferences of seeking nontraditional forms of help. There is a myriad of complex and multifaceted explanations that must be examined to reduce disparities in mental health access and treatment. Socio-cultural factors and ethnicity are essential determinants that heavily influence the utilization of mental health treatment services.

Socio-cultural factors mediate how the individual expresses emotions, interprets unpleasant symptoms, and manifests mental illness (Copeland, 2006). This study's significant findings on mental health beliefs and spirituality have added to the interpretation of the socio- cultural context for older African American females. The social context includes the ecological environment, personal relationships, social support systems and their interaction. The cultural context is comprised of the ideas, beliefs, norms, values, attitudes, and knowledge that characterize a particular group of people (Copeland, 2006). Mental health beliefs influence older African American female's mental health status; the way individuals perceive, interpret, define, and give meaning to health and illness. This study's findings have also unearthed the practice of spirituality as a cultural norm among older African American females that appear to impact the interpretation of mental illness and possible cures. Consequently, in the social worker and client relationship social cultural factors will influence every interaction, decision-making process, expectations, and adherence to treatment.

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