

**MENTAL HEALTH TREATMENT SEEKING AMONG OLDER ADULTS WITH
DEPRESSION: THE IMPACT OF STIGMA AND RACE**

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Stigma associated with mental illness continues to be a significant barrier to help seeking, leading to negative attitudes about mental health treatment and deterring individuals who need mental health services from seeking care. Individuals suffering from mental health symptoms who can benefit from mental health treatment choose not to pursue services, or begin treatment but drop out prematurely, to avoid the label of ‘mentally ill,’ as well as the stereotypes, prejudice and discrimination associated with bearing such a label. Empirical investigation suggests that the stigma of having a mental illness may exert an adverse influence on attitudes toward mental health treatment and service utilization patterns by individuals with a mental health diagnosis. There is, however, a dearth of research that examines the way in which stigma influences attitudes toward seeking mental health services among aging populations and racial/ethnic minorities.

This mixed methods study examined the impact of stigma on racial differences in treatment seeking attitudes and behaviors among older adults¹ with depression. Results indicate that older adults with depression have high levels of public stigma and do not intend to seek, nor are they currently engaged in mental health treatment. Results also suggest that African American older

¹ The term older adults will be used throughout this paper to represent individuals aged 60 and older.

adults endorse higher internalized stigma and less positive attitudes toward seeking mental health treatment than their white counterparts. In addition, high level of internalized stigma was related to negative attitudes toward seeking treatment and partially mediated the relationship between race and attitudes toward treatment. Older African Americans in the current study identified a number of experiences living in the black community that impacted their treatment seeking attitudes and behaviors, which led to their identification and utilization of more culturally endorsed coping strategies to deal with their depression.

Findings from this study provide a greater understanding of the stigma associated with having a mental illness and its' influence on attitudes and intentions toward seeking mental health services among older adults, particularly African American elders. Additionally, findings from this study provide impetus for a number of practice implications and suggestions for future research.

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PREFACE

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1.0 INTRODUCTION

I wanted to tell her that if only something were wrong with my body it would be fine, I would rather anything be wrong with my body than something wrong with my head.

- Sylvia Plath, 1966, p.193

1.1 PURPOSE OF THE STUDY

Despite the gains in research on the stigma associated with mental illness, there continues to be a lack of literature that addresses the impact of stigma on attitudes toward seeking mental health treatment in elderly populations, particularly among African American older adults. In addition, there is a limited amount of empirical research which examines the experiences of the stigma associated with having a mental illness from the perceptions of individuals who feel stigmatized themselves (Schuzle & Angermeyer, 2003). Utilizing a sequential mixed methods design with a representative sample of 248 older adults in Allegheny County, Pennsylvania, this study investigated the complex nature of stigma as it served as a barrier to mental health treatment for older adults suffering from ²depression. To this end, the study set three important objectives:

² The term depression is used to indicate depressive symptoms, not major depressive disorder (MDD).

- To examine the impact of the stigma associated with mental illness on mental health treatment seeking attitudes and behaviors among older adults with depression;
- To identify modifiable factors related to stigma associated with mental illness which can be utilized to develop effective, culturally competent interventions to decrease this stigma in aging populations; and
- To examine how experiencing multiple, concurrent stigmas (e.g. mental illness, aging and racial minority status³) impacts treatment seeking among older African Americans with depression.

³ The term racial minority status will be used throughout this paper to represent African Americans.

1.2 BACKGROUND AND SIGNIFICANCE

1.2.1 Prevalence of Depression Among Older Adults

The 1999 Surgeon General's Report on mental health states that close to 20 % of the U.S. population age 55 and older experience mental health disorders (DHHS, 1999). Current research suggests that mental health disorders are actually more common among older adults than current estimates report, with some studies reporting psychiatric disorders in 33% of individuals 70 years of age and above (Olafsdottir, Marcusson, & Skoog, 2001). This high rate of mental health disorders seen among older adults is likely due to increased medical problems, functional impairments and other stressors, both psychological and physiological, that accompany old age (Borsen, Bartels, Colenda, Gottlieb, & Meyers, 2001). Aging also carries with it an increased risk of degenerative organic disorders such as Alzheimer's and Parkinson's and specific mental illnesses such as dementia and depression (Rosenstein, 1998).

Depression is a common psychiatric disorder, affecting nearly 18.8 million adults or about 9.9% of the U.S. population in a given year (NIMH, 2003). Depression in the elderly is a major public health concern leading to increased disability and mortality. Depression among elderly persons is widespread and is often undiagnosed and untreated. Eight to 20% of older adults in the community suffer from depressive symptoms and an estimated 6% of Americans aged 65 and older (roughly 2 million individuals) have a diagnosable depressive illness (Gallo & Lebowitz, 1999). It is estimated by 2030, the number of older adults with depression will nearly double the current numbers (Jeste et al., 1999).

These projections are largely based on the aging of the “baby boomer” cohort and greater life expectancy. Despite these high prevalence rates, few older adults (less than 3%) report seeing a mental health professional for treatment, a rate lower than any other adult age group (Bartels et al., 2005). Older adults are especially underrepresented in outpatient specialty mental health care (Corrigan, 2003; Milazzo-Sayre et al., 2000; Zuvekas, 2001).

Without appropriate mental health treatment, major and minor depression in older adults is associated with significant disability and impairment, including impaired quality of life, increased mortality, and poor health outcomes (Bartels et al., 2005; DHHS, 1999). Likely related to the high rates of depression, older adults have the highest rate of completed suicide (DHHS, 1999). With the numbers of older adults rapidly increasing in the United States, untreated mental illness among older adults is one of the most significant challenges facing the mental health service delivery system (President’s New Freedom Commission on Mental Health, 2003), especially considering that the combination of psychotherapy and psychopharmacology is highly effective in treating mental health disorders among older adults (DHHS, 1999; Reynolds et al., 2006).

1.2.2 Racial Disparities in Mental Health Treatment

African American older adults suffer more psychological distress than their white counterparts due to their exposure to and experiences with racism, discrimination, prejudice, poverty, and violence (DHHS, 2001); and they tend to have fewer psychological, social, and financial resources for coping with this stress than their white counterparts (Choi & Gonzales, 2005). Despite research which suggests similar rates of depression among African Americans and whites (DHHS, 1999), racial disparities continue to exist in mental health service utilization.

African Americans are significantly less likely to seek mental health services than their white counterparts (Miranda & Cooper, 2004). While only one-third of all individuals with a diagnosable mood disorder seek mental health treatment, African Americans seek treatment at a rate half that of their white counterparts (Brown & Palenchar, 2004; DHHS, 1999). These disparities continue even after initial barriers have been overcome. African Americans attend fewer sessions when they do seek specialty mental health treatment, and are more likely than their white counterparts to terminate treatment prematurely (Brown & Palenchar, 2004, Miranda & Cooper, 2004). African Americans are more likely to utilize their informal networks, the church, and their primary care physicians to seek help with mental health concerns (Administration on Aging, 2001). Unfortunately, many of these individuals may not have training in dealing with mental health concerns, let alone geriatric mental health.

Negative attitudes towards mental health treatment significantly impact the help-seeking behaviors of adults. Utilizing a nationally representative sample, Diala and colleagues (2000) found that individuals who endorsed negative attitudes toward treatment were five times less likely to seek mental health services than those with more positive attitudes toward mental health treatment. Research suggests that as compared to their white peers, African American adults hold more negative attitudes towards seeking mental health treatment (Snowden, 2001); however, the relationships among race, attitudes and mental health treatment utilization have not been explored in depth among older adults. Recognizing the importance of attitudes toward mental health treatment as a significant predictor of treatment seeking behaviors, it is imperative to identify the factors that negatively impact these attitudes and perceptions among older adults with depression.

1.2.3 The Stigma of Mental Illness

The stigma associated with having a mental illness may be an important factor that influences treatment-seeking attitudes and behaviors, and may in part account for disparities in service utilization. According to Goffman (1963), stigma is an identified mark or characteristic, which disqualifies those possessing the mark from full social acceptance in society. This includes the negative perceptions, attitudes, and beliefs held about individuals that bear such a mark. Stigma theory posits that psychiatric labels activate negative images about mental illness that are applied to the individual bearing that label by others or by him or herself (Link et al., 1989). The resulting stigmatization has been identified as one of the most significant barriers to mental health treatment and contributes to poor quality care, particularly for African Americans (Gary, 2005).

Empirical investigation suggests that the stigma associated with mental illness exerts adverse influence on attitudes toward mental health treatment and service utilization patterns by African Americans with mental health concerns (Corrigan, 2004). Research also indicates African Americans are more likely to experience stigma about mental illness than their white counterparts (Cooper-Patrick et al., 1997). Despite gains in research on the stigma of mental illness, there is a dearth of literature that examines the impact of the stigma associated with having a mental illness on mental health treatment seeking in aging populations, particularly among African American older adults.

Stigma theory also recognizes that having a mental illness manifests itself in two distinct, yet overlapping ways – public stigma and internalized stigma (Corrigan, 2004). Public stigma refers to the negative beliefs, attitudes, and conceptions about mental illness held by the general population, which lead to stereotyping, prejudice, and discrimination against individuals with mental health disorders (Corrigan, 2004). An individual's perceptions about society's attitudes and

beliefs about their mental health status often lead to negative attitudes about mental health treatment and thus become a barrier to help-seeking. Internalized stigma refers to devaluation, shame, secrecy, and social withdrawal, which are triggered by applying negative stereotypes about mental illness to oneself (Corrigan, 1998). Living in an environment which sanctions the stigmatization of people with mental illness, an individual with a mental health disorder may accept and internalize these stigmatizing attitudes and beliefs that appear to be endorsed within society (Corrigan, 1998; Link & Phelan, 2001). According to Cooper, Corrigan and Watson (2003), there is an inverse relationship between stigma and treatment seeking. Individuals who perceive society as holding stigmatizing beliefs about mental illness, and individuals who internalize stigma are less likely to seek mental health treatment. This finding has been validated in additional investigations (Leaf et al., 1987; Sirey et al., 2001).

The relationship between stigma and treatment seeking attitudes and behaviors may be particularly pertinent among older adults. Katona and Livingston (2000) identified the stigma of mental illness as the most fundamental reason why older adults chose not to seek mental health services. The Surgeon General's report on mental health (1999) highlighted stigma as a powerful obstacle to seeking care among the elderly. Sirey and colleagues (2001) found that perceived stigma about mental illness predicts early treatment discontinuation in elderly mental health patients who suffer from depression. Further, older African Americans with depression experience multiple, concurrent stigmas such that they are additionally stigmatized due to bearing more than one stigmatizing mark (e.g. mental illness, aging, and racial minority status). However, to date, the relationship between stigma associated with mental illness, age, race, and mental health service utilization has received little attention.

The empirical research examining mental illness stigma has not addressed its impact in aging populations, nor has it investigated the impact of mental illness stigma and race on treatment utilization (Gary, 2005). There is also a shortage of literature that examines the experiences of stigma from the perceptions of individuals who are stigmatized. In addition, research has not sufficiently addressed the impact of stigma on individuals who are experiencing multiple, concurrent stigmas. This study contributes to this understudied area of mental health research by utilizing a mixed methods approach to examine the impact of the stigma associated with having a mental illness and race on treatment seeking among older adults with depression.

1.3 RESEARCH QUESTIONS AND HYPOTHESES

This study focused on four distinct areas of interest: 1) racial differences in treatment seeking attitudes and behaviors among older adults with depression; 2) racial differences in perceptions and experiences of the stigma associated with having a mental illness among older adults with depression; and 3) the relationship between stigma and treatment seeking attitudes and behaviors among older adults with depression. These first three areas of focus were examined quantitatively by means of conducting a cross sectional survey. The study also focused on 4) the impact of experiencing multiple, concurrent stigmas on treatment seeking attitudes and behaviors among older African Americans with depression. This fourth area of interest builds upon the first three areas of inquiry and was addressed qualitatively via semi-structured interview. In sum, given these four areas of focus, this study addressed the following questions and hypotheses:

1. Racial differences in treatment seeking attitudes and behaviors

Q-1: Do attitudes and behaviors toward seeking mental health treatment differ by race among older adults with depression?

H.1a: African American older adults have less positive attitudes toward seeking mental health services than their white counterparts.

H.1b: African American older adults are less likely to intend on seeking mental health services than their white counterparts.

H.1c: African American older adults are less likely to be engaged in mental health services than their white counterparts.

2. Racial differences in experiences and perceptions of mental illness stigma

Q-2: Do perceptions of and experiences with mental illness stigma differ by race?

H.2a: African American older adults perceive more public stigma⁴ about mental illness than their white counterparts.

H.2b: African American older adults experience more internalized stigma⁵ about mental illness than their white counterparts.

3. The associations between mental illness stigma and treatment seeking

Q-3.1: To what extent does mental illness stigma relate to the treatment seeking attitudes and behaviors of older adults with depression?

H.3a: High perceptions and experiences of stigma will be related to more negative attitudes toward treatment for both African American and white older adults.

H.3b: High perceptions and experiences of stigma will be related to reduced intention to seek mental health treatment for both African American and white older adults.

H.3c: Older adults who perceive and experience high amounts of stigma will be less likely to be engaged in mental health treatment than those who perceive low stigma.

⁴ Public stigma refers to negative perceptions of how the public views people with a mental illness.

⁵ Internalized stigma refers to the application of negative stereotypes about mental illness to oneself.

Q-3.2: To what extent does mental illness stigma mediate the relationship between race and mental health treatment seeking attitudes and behaviors?

H.4a: Stigma (public and internalized) partially mediates the relationship between race and attitudes toward seeking mental health treatment.

H.4b: Stigma (public and internalized) partially mediates the relationship between race and intentions toward seeking mental health treatment.

H.4c: Stigma (public and internalized) partially mediates the relationship between race and engagement in mental health treatment.

4. The effect of experiencing multiple, concurrent stigmas on treatment seeking attitudes and behaviors

Q-4: How does experiencing multiple, concurrent stigmas impact the treatment seeking attitudes and behaviors of older African Americans with depression?

(This exploratory question will be addressed via semi-structured interview –

See Appendix)

1.4 SIGNIFICANCE TO SOCIAL WORK PRACTICE AND RESEARCH

There are a number of significant contributions from this study to the areas of social work practice, mental health care policy and public health that aim to improve the lives of older adults, their families and caregivers. First, this study refines our conceptual understanding of stigma associated with mental illness, and highlights how this influences the mental health treatment seeking attitudes and behaviors of older adults. A greater understanding of the way in which the stigma associated with having a mental illness impacts attitudes toward mental health services aids social work practitioners in identifying and developing interventions to reduce the stigma associated with mental illness. This understanding additionally helps to eliminate stigma as a barrier to seeking mental health treatment among older adults with depression. The identification of modifiable factors relating to both perceived public and internalized stigma is appropriate for developing effective, culturally competent interventions to decrease mental illness stigma among older adults. These interventions can be tailored to: community-based public education efforts; clinical techniques to reduce the effects of internalized stigma; psycho-education strategies for family members and caregivers of older adults suffering from mental health disorders; and effective training strategies for mental health clinicians and service providers.

For example, internalized stigma may be a useful and malleable clinical indicator to monitor and treat. Decreasing internalized stigma can be addressed as a treatment goal, or as the target of therapeutic intervention. Targeting and reducing internalized stigma in treatment settings may improve client attitudes toward mental health services and treatment adherence. Additionally,

public stigma about mental illness, which is related to internalized stigma, is just as harmful and must be reduced. Identifying the role and impact of public stigma provides an opportunity to develop community-based public education campaigns designed to raise awareness about depression and aging, and to reduce the stigma associated with seeking mental health treatment. These campaigns would likely increase the information and knowledge in the community about depression and mental health treatment, which will hopefully improve attitudes and treatment utilization by older adults suffering from depression.

Second, with a racially diverse sample of older adults identified as being depressed in Allegheny County, Pennsylvania, this study gathers data regarding both the mental health needs of and the barriers to seeking mental health treatment for this population. This data is essential for designing effective services to meet the unique needs of older adults suffering from depression, particularly as the aging population in the United States continues to grow. The number of individuals living to 85 years and older has increased dramatically in the past few decades, and currently individuals age 65 and older make up close to 12% of the population. Predictions suggest that by 2040, individuals aged 65 and older will make up approximately 20% of the U.S. population (United States Census, 2004).

Further, the data obtained from this study may be generalized to similar populations in other cities, and utilized in the planning of mental health care policy that targets the elderly. Therefore, the findings from this study contribute to the development of policy initiatives designed to improve access to quality mental health services for older adults suffering from depression. These findings are particularly beneficial for improving access to mental health services for older African Americans, a group which has been consistently shown to underutilize mental health services (Snowden, 2001).

Finally, this study contributes to an understudied area in geriatric social work. Empirical research examining the stigma associated with having a mental illness in aging populations has not been fully addressed, nor have the intersections between the stigma associated with mental illness, race and mental health treatment utilization been identified and discussed. While a vast amount of research has assessed the attitudes and beliefs held by the general public about certain stigmatized conditions, there is a shortage of research that examines the experience of stigma from the perceptions of individuals who feel stigmatized. In addition, research has not sufficiently addressed the impact of stigma on individuals who simultaneously experience multiple stigmas. This study advances knowledge that helps social work practitioners 1) design effective and culturally appropriate interventions for older adults with depression and their families and caregivers, as well as 2) develop mental health care policy and programs that best meet the needs of this population.

2.0 REVIEW OF THE LITERATURE

Although there is a plethora of literature on the general phenomenon of stigma, the majority of empirical research examining the effects of the stigma associated with having a mental illness have not been addressed in aging populations, nor have the intersections of 1) mental illness stigma, 2) race and 3) mental health treatment utilization been studied. There is also a lack of research that examines the experiences of stigma from the perceptions of individuals who have experienced the stigma of having a mental illness. This chapter begins with a discussion of seeking mental health care, and outlines some of the identified barriers to help seeking. Attitudes toward seeking mental health treatment are presented and factors that influence older adult attitudes are discussed in detail. Stigma is highlighted as a factor impacting older adult attitudes toward mental health services and as a barrier to seeking mental health treatment. In order to have a better understanding of the concept of stigma, this chapter continues with a discussion of stigma theory and the stigma associated with having a mental health disorder. Next, a review of the literature related to the impact of stigma on mental health treatment in African Americans and older adults will be presented. The chapter concludes with a synthesis of the information outlined in this chapter and highlights the need for research to address the intersections of mental illness stigma, race and mental health treatment.

2.1 MENTAL HEALTH TREATMENT SEEKING

Since 1986, when Lasoski suggested that the quality of care provided to the older adult population was poor, geriatric scholars as well as the mental health community at large have worked tirelessly to improve and expand mental health services for older adults. Despite significant improvements in the quality and availability of mental health treatment, the utilization of mental health services by the older adult population continues to be stifled. Research suggests that close to 2.4 million older adults in the United States are in need of mental health treatment, yet less than 1 million of them actually receive services (Estes, 1995). Older adults are less likely than their younger adult counterparts to seek and utilize specialty mental health services and are underrepresented in outpatient treatment (Milazzo-Sayre et al., 2000; Zuvekas, 2001). In their study of mental health service utilization, Sirey, Bruce, Alexopoulos, Perlick, Raue, Friedman & Meyers (2001) found that 24% of older adults discontinued mental health treatment within six weeks, as compared to the 13% discontinuation rate of the younger adults in their study.

These statistics have led researchers and scholars to question whether the underutilization of mental health treatment among older adults is an effect of aging or rather due to a cohort effect (Pijl & Sytema, 2003). If the underutilization of mental health services were an effect of aging, we would expect individuals who are now older adults to have sought mental health treatment when they were younger, but not to have sought mental health services in their old age. Alternatively, a cohort effect would suggest individuals who are now older adults chose not to utilize available mental health services when they were younger and they continued to avoid those services as they age. This question has not been fully addressed by current research; however a number of factors acting as barriers to mental health treatment seeking among older adults have been identified.

2.2 ATTITUDE TOWARD SEEKING MENTAL HEALTH TREATMENT

If individuals in need of mental health services choose not to seek or utilize the services that are available to them, it is likely that barriers exist which prevent those individuals from attaining mental health treatment. And in fact, a number of barriers to seeking and accessing mental health care among older adults have been identified. In conducting focus groups with geriatric mental health clinicians to identify the most salient barriers to mental health treatment for their older adult clients, Choi and Gonzales (2005) identified seven barriers: 1) society's and older adults' own ageism leading to a misunderstanding of and lack of awareness of mental health problems; 2) perceived sense of shame and stigma surrounding mental illness; 3) self-perceived cultural and language barriers, along with a fear and distrust of the treatment system; 4) lack of information on the availability of treatment programs; 5) misperception that only doctors can make referrals; 6) primary care physicians' knowledge deficit about mental health disorders; and 7) perception that treatment is not affordable and lack of transportation.

An additional barrier that is particularly relevant to older adults is negative attitudes. Many people, regardless of age, have negative attitudes about mental health treatment and mental illness. However, the attitudes of older adults may differ from their younger counterparts. There are a number of factors that influence older adults' attitudes toward seeking mental health treatment including: 1) attitudinal barriers; 2) the service delivery system; 3) culture and spirituality; 4) support system; and 5) stigma. These first four factors will be discussed in detail in the next few paragraphs and the impact of stigma on treatment seeking attitudes and behaviors will be discussed further in the following sections.

2.2.1 Attitudinal Barriers

If identified barriers to mental health treatment utilization are not significantly different for older persons as compared to younger persons, one explanation for the underutilization of mental health services by older adults may be evident in the attitudes about seeking mental health treatment held by the current older adult generation. Negative attitudes toward mental illness and mental health treatment have been identified as a barrier to mental health service utilization among older adults. In a study conducted by Von Sydow and Reimer (2001), one-third of their study participants who declined mental health treatment did so due to their negative attitudes towards psychotherapy. Thus, it is logical to suggest that older adults who are more receptive to mental health services are more likely to actually utilize those services when in need.

Lundervold and Young (1992) assessed the mental health attitudes of 50 older adults across seven areas that may impact older adults' use of mental health services. Utilizing the Older Adults' Attitudes and Knowledge toward Mental Health Services Scale, they assessed the following areas: 1) knowledge of aging and mental health, 2) cost of services, 3) access to services, 4) stigma, 5) effectiveness of treatment, 6) religiosity, and 7) openness to discussing mental health issues. The results of their study suggest that compared to their younger adult counterparts, older adults hold the most negative attitudes toward mental health treatment in the areas of religiosity and stigma. Interestingly, they also found that older adults have the least amount of knowledge about psychopathology and aging, when compared to people of all ages.

Hatfield (1999) suggests that the current generation of older adults in the United States, aged 65 or older, grew up in a time of institutionalism, harsh psychotropic medications, and extreme stigma toward mental health disorders and may therefore experience embarrassment or fear at the thought of mental health treatment. This idea supports the cohort effect hypothesis,

such that current older adults formed their ideas about the mental health service delivery system when they were younger, and may have not changed these ideas despite current improvements in this system. Older adults seem to have formed negative attitudes toward particular mental health and providers' practices, many of which are no longer advocated by the mental health community.

In a meta-analysis of 60 studies on the public's attitudes toward mental health treatment, Von Sydow and Reimer (2001) found that older people reported more skepticism about mental health treatment and the skills of mental health professionals than did younger adults. They also found that when compared to younger people, older adults held less clear ideas about the services offered by mental health care providers (Von Sydow & Reimer, 2001). The lack of knowledge and awareness is especially concerning among older racial and ethnic minorities. Choi and Gonzales (2005) found that many minority older adults currently suffering from mental health disorders are not aware of available mental health treatment programs and often wrongly believe that available programs are only for people who are severely and persistently mentally ill. This lack of knowledge and awareness lends further support to the cohort effect hypothesis. It seems that while the general public has had a continuous increase in mental health knowledge over the past few decades, the current older adult generation developed their attitudes toward mental health care in a time before accurate mental health care education was widespread (Von Sydow & Reimer, 2001).

Due to the belief that mental illness is a normal part of aging, mental health disorders among older adults often go undetected and unrecognized by the older adults themselves and as well as their family members. Morano and DeForge (2004) conducted focus groups with senior citizens and mental health care providers to identify older adults' views on mental health. In the

four focus groups conducted with older adults, the participants identified anxiety, sadness, and depression as emotional problems of the elderly that are a normal part of the aging process, and therefore, mental health treatment is not necessary.

In a study of attitudes toward depression, Davidson and Connery (2003) asked older and younger adult participants to rate their level of agreement with specific statements about a vignette character experiencing common depressive symptoms. While all other information was identical, approximately half of the participants received a vignette where the character was 30 years old and the other half received vignettes where the character was 70 years old. Simply based upon the age of the character in the vignettes, study participants endorsed different perceptions of the individual's symptoms. When the character was presented as being 30 years old, study participants perceived the subject to have a mental illness, and believed the participant should seek mental health treatment. However, when the subject was identified as 70 years old, participants thought the subject was having normal experiences associated with aging and believed the participant did not need to seek mental health treatment. Additionally, older participants were more likely than their younger counterparts to believe that the character was experiencing problems common to all individuals and that the character should pull himself together, especially when the character was presented as being 70 years old. Interestingly, Choi and Gonzales (2005) found that even when older adults suspected that the symptoms may not be a part of the normal aging process, they had a hard time accepting that they had a mental health disorder. These attitudes may cause an older adult in need of mental health treatment to avoid seeking help, believing that their symptoms are a normal part of the aging process and therefore do not require treatment. Similarly, Marwaha and Livingston (2002) found that many older adults believed that nothing could be done to help individuals suffering from depression.

This lack of knowledge and awareness may be related to a misunderstanding held by many older adults that mental health disorders are psychotic disorders that are inherited and unchangeable. This, in turn, contributes to pessimistic attitudes and the belief that mental health treatment is not likely to be effective (Lebowitz & Niedereche, 1992). Older adults sometimes view their mental health problems as being unworthy of professional help. They tend to consider the symptoms of mental illness to be signs of personal weakness and spiritual inadequacy (Ray, Raciti & MacLean, 1992). Therefore, instead of turning to the formal health care system, they turn to their informal support network for help. As they age, older adults may additionally have an increasing tendency to accept current life situations and may feel less desire to improve their current physical and emotional well being (Horwitz & Uttaro, 1998). The disinclination to seek mental health treatment may also reflect the strong emphasis that older adults tend to place on their independence and their ability to take care of themselves.

2.2.2 The Service Delivery System

Lack of interagency coordination also impacts the attitudes toward mental health treatment held by older adults (AOA, 2001). Primary care physicians often lack geriatric mental health training, do not regularly ask about mental health symptoms, do not notice their older patient's mental health problems, and if they do they often gloss over the issue without providing an adequate mental health referral (AOA, 2001). The lack of mental health care professionals with specialized geriatric training is a critical issue. The number of geriatric social workers is extremely inadequate (Olson, 2007), and there are few Masters in Social Work programs with a specialization in geriatric mental health. Mental health professionals who lack geriatric mental health training often lack the commitment and competence necessary to meet the needs of older

adults (Lasoski, 1986). As a result, treatment facilities as well as community mental health centers rarely offer services specifically designed for older adult clients (AoA, 2001).

Due to a history of discrimination and extreme maltreatment against minority clients, the mental health service delivery system in the United States has created mistrust and fear of mental health professionals and the service delivery system among racial and ethnic minorities (DHHS, 1999, 2001; Snowden, 2003). This fear and lack of trust seems to be particularly evident among racial and ethnic minority elders. Choi and Gonzales (2005) found that older racial and ethnic minority clients tend to have deep-rooted suspicions about the mental health care system. They often fear that they will be misunderstood and treated unfairly by mental health care providers. The perceptions of cultural differences as well as the incidents of cultural insensitivity in the service delivery system experienced by older racial and ethnic minorities are a powerful deterrent to the utilization of mental health services (Caldwell, 1996) and lead to very negative attitudes about seeking mental health treatment.

2.2.3 Culture and Spirituality

The culture, or set of beliefs, norms, values, and traditions, shared by a group of people from the same racial/ethnic background, can impart a strong influence on attitudes toward mental illness and on mental health treatment seeking behaviors. Research has suggested that African American older adults may hold more negative attitudes toward mental illness. This may be due to the tendency of older African Americans, as well as other racial and ethnic minorities, to view a mental illness like depression as a personal weakness, as opposed to a medical illness that carries less shame and stigma. Previous studies have also acknowledged that African American older adults in the United States have lived under a socio-cultural system that has denied them

equal access to traditional healthcare services, as well as specialized mental health treatment. Therefore, African American older adults have developed culturally endorsed coping strategies to deal with their mental health care needs. These strategies include engaging in traditional self-care, relying on their informal support networks, prayer and the belief that God heals all, and seeking mental health treatment only as a last result (Neighbors, 1986). Traditional self-care, including prayer and seeking care from the clergy rather than mental health care professionals, is related to African American older adults' strong emphasis on spirituality. In their focus groups, older African American participants were often more religious and reported the use of prayer as a way of coping with mental health issues. Additionally, the church was identified as a financial, social and general resource. The reliance on the self and on the church is likely a result of being conditioned to live with and endure their mental health symptoms as opposed to seeking professional mental health treatment (Choi & Gonzales, 2005). These attitudes, despite displaying the resiliency and strength of African American culture, can impede the treatment seeking behaviors of older adults with depression.

2.2.4 Social Support

Aging is often accompanied by a shrinking social circle and older adults who have mental health disorders are even less likely to have access to and help from their informal social networks. Depressed people often believe that others will respond to them negatively if they seek help (Givens et al., 2007), and this belief may be particularly strong among the current older adult generation. The influence of others' views towards mental illness and treatment seeking seems to play a critical role in the development of attitudes about help seeking, with recommendations from close family and friends being an important facilitator for those who have sought mental

health care (Dew et al., 1988). Without a support system that advocates and links them to the formal service systems, older adults with mental disorders are not likely to access mental health treatment. Givens and colleagues (2007) found that perceiving others who would support the use of mental health treatment was significantly and positively correlated with positive attitudes about seeking mental health services and the acceptability of diverse mental health treatments. Therefore, lacking a support system, or having an informal network that does not support the use of mental health treatment, would likely have the opposite effect and be associated with negative attitudes about seeking mental health treatment. Unfortunately, due to the other factors we have discussed, such as the belief in self-reliance and the tendency to view having mental illness as a personal weakness, it is likely that the informal support networks surrounding older African Americans will be made up of individuals who are not particularly supportive of utilizing mental health treatments to handle one's emotional distress.

2.2.5 Stigma

In addition to the stigma associated with having a mental health disorder, stigma is also associated with seeking mental health treatment. Due to the strong sense of stigma and shame about mental illness and seeking mental health treatment, older adults may try to deny or hide their mental health problems from others. In addition, they may become hesitant to seek mental health treatment due to a fear of being labeled as “crazy” and of being institutionalized (AoA, 2001). Experiences of stigmatization or the perception of being stigmatized for having a mental health disorder can lead to negative attitudes about seeking mental health treatment and can deter individuals who need treatment from seeking care. In the next section I will begin to discuss stigma in more detail and highlight its impact on treatment seeking attitudes and behaviors.

2.3 THEORETICAL FRAMEWORK

2.3.1 Defining Stigma

According to Goffman (1963), stigma is an identified mark or characteristic, which disqualifies those possessing the mark from the full social acceptance of society. This includes the perceptions, attitudes, and beliefs held about individuals that have this characteristic. Although stigma research has grown exponentially since Goffman's (1963) classic work, the current stigma literature highlights distinct variability in the perspectives on stigma as a concept. This variability appears to derive from the multi-disciplinary contributions to the stigma literature, and from the broad array of circumstances to which stigma has been applied (Link & Phelan, 2001). These multiple applications of stigma provide useful opportunities to view the relationship between stigma and mental illness.

Link and Phelan (2001) present a conceptualization of stigma, which is particularly relevant to an understanding of the stigma of mental illness and, thus, serves as the guiding theory for this study. In order to address the main limitations of previous theoretical frameworks regarding stigma, that is, their lack of clarity and individualistic focus, Link and Phelan (2001) provide a more detailed and comprehensive framework of stigma development. This framework encompasses five interrelated components: labeling, stereotyping, separation, status loss, and discrimination.

Labeling describes the process whereby individuals begin to distinguish and label human differences. Stereotyping occurs when dominant cultural attitudes and beliefs connect labeled and undesirable human characteristics to negative stereotypes. When separation occurs, individuals who possess an undesirable characteristic are separated into distinct categories, and

labeled with the negative stereotype. During status loss, labeled individuals experience the loss of previously held status in society, which often leads to discrimination. This process of stigmatization occurs only when the differential access to social, economic, and political power allows for these components to occur. Thus, stigma exists when the interrelated components occur within a power structure that condones them. This conceptualization captures stigma development as a process that occurs within a specific social-political context. Not only does Link and Phelan's (2001) theoretical conceptualization include past research on the social cognitive processes of stigma acquisition, it also broadens the individualistic focus by addressing the structural basis of stigma.

2.3.2 The Structural Basis of Stigma

One challenge to understanding the etiology of stigma is explaining how any given society comes to share stigmatizing beliefs. Many societies share certain stigmatizing beliefs, as evidenced by the existence of universal stigmas and/or individual characteristics, such as mental illness and skin color, which are negatively branded across many cultures. This multicultural phenomenon suggests that there may be a common underlying component to stigma. Despite these universalities, stigmas are largely determined by the dominant local culture of a society or group, and can change for better or worse over time (Stangor & Crandall, 1999).

This structural perspective lends itself to viewing stigma as a component of power. Power is essential to the social construction of stigma and stigmatizing beliefs (Link & Phelan, 2001). Stereotypes and stigma lead to discriminatory consequences and outcomes for individuals if the labels and stereotypes, about less powerful groups, are created by more powerful groups. In a dominant culture, groups with power tend to oppress those without power, and have the ability to

treat individuals in accordance with certain stereotypic beliefs and in stigmatizing ways. Consider the stigmatization of race and the stereotypic beliefs held about African Americans. It was the power of English colonists that allowed the enslavement and subsequent stigmatization of African people. Long after the abolishment of slavery, African Americans were believed to be genetically inferior to whites, incapable of intellect, and were portrayed as savages that were less than human (Fazio, Jackson, Dunton & Williams, 1995). The systematic and continued oppression of African Americans identifies people of African descent as a stigmatized group in the United States. As an oppressive force, power is significantly determinative of the construction of stereotypes and stigmas in our society.

2.3.3 Social Psychological Research on Stigma Acquisition

The social cognitive approach within the field of social psychology has contributed a significant proportion of the empirical research on stigma theory (Stangor & Crandall, 1999). Social psychologists have utilized this approach to identify how people unconsciously and routinely construct schemas and social categories, and subsequently link these categories to relevant stereotypic beliefs. Historically, stigma theorists using the social cognitive approach focused on understanding the stigmatization of social deviants such as thieves, the physically disabled, adulterers, and traitors (Akerstrom, 1986; Becker, 1956) and subsequently the stigmatization of racial and ethnic minorities (Steele & Aronson, 1995). It is only more recently that researchers began to examine the unconscious social cognitive process underlying the categorization, stereotyping, discrimination, and overall stigmatization of individuals with mental illness (Corrigan & Watson, 2002; Hayward & Bright, 1997; Link et al., 1997; Link & Phelan, 2001).

Figure 1 shows the social cognitive model often used in the study of stigma and mental illness that highlights the cognitive, affective, and behavioral components of stigma development, that is the formation of stereotypes, the experience of prejudice, and the practice of discrimination (Corrigan & Watson, 2002). Stereotypes allow people to quickly generate impressions and expectations of individuals who belong to a stigmatized group (Hamilton & Sherman, 1994). Individuals who endorse these stereotypes, in turn, experience negative emotional reactions and prejudicial attitudes towards individuals with mental illness. Ultimately, prejudice generates discrimination, the behavioral response, which yields unjust and unequal treatment towards individuals with mental illness based solely upon their membership in this stereotyped and stigmatized group (Corrigan, 2007, 2004; Crocker, Major & Steele, 1998).

Figure 1: Components of Stigma

Public Stigma	Internalized Stigma
<p><u>Stereotypes:</u> Negative attitudes or beliefs (real or perceived) held by society about individuals with mental illness.</p>	<p><u>Stereotypes:</u> Negative attitudes or beliefs about oneself because one has a mental illness.</p>
<p><u>Prejudice:</u> Agreement with belief and/or negative emotional reaction to individuals with mental illness.</p>	<p><u>Prejudice:</u> Agreement with the negative attitude or belief about the self.</p>
<p><u>Discrimination:</u> Behavioral response to prejudice.</p>	<p><u>Discrimination:</u> Behavioral response to the prejudice toward oneself.</p>

Source: Corrigan (2007)

2.3.4 Stigmatization as a Matter of Degree

Link & Phelan's (2001) conceptualization helps aid in the understanding of both the structural basis of stigma development and the social cognitive process whereby stigma emerges, whereas the social psychological work of Jones and colleagues (1984) posits six dimensions that explain how some stigmatizing conditions become more or less stigmatizing than others. They first suggest visibility as a dimension of a stigma, which indicates how obvious and detectable the characteristic is to others. Second, they address the course of the stigmatizing condition. Is it reversible or will it become more salient and debilitating over time? Next, they discuss the degree to which the stigma interferes with an individual's ability to engage in basic interpersonal interaction. Fourth, they address the extent to which the stigma is perceived as unattractive. Fifth, the authors discuss the origin of a stigma, that is, the perceived controllability of the stigma and the perceived responsibility for creating the stigma on the part of the stigmatized individual. The final dimension is the perceived danger of a stigmatizing condition to others.

In general, an individual's perceived responsibility for creating or controlling the condition carries great influence on how people respond to individuals with a stigmatizing mark (Link et al., 2002). In addition to controllability, the perceived danger and visibility of a stigma have emerged as the most central dimensions in predicting how others will respond to individuals with specific stigmatizing conditions (Frale, 1993).

In summary, the theoretical framework on stigma yields a number of significant and useful insights that may yield a broader understanding of the stigma associated with mental illness. Focusing on the structural basis of stigma development, the social cognitive processes and behavioral consequences of stigma acquisition, and the extent to which a personal attribute is stigmatizing has been particularly relevant to the study of stigma and mental illness.

2.4 STIGMA ASSOCIATED WITH MENTAL ILLNESS

Individuals with depression often struggle with a dual problem. First, they must learn to cope with the symptoms of the disease itself, which can include feelings of hopelessness, anxiety, severe mood swings, and suicidal ideations. These symptoms can impact the ability for a clinically depressed individual to function at work and at home, and can negatively impact the individual's quality of life. Second, the misunderstandings held by the individual's community, and of society in general, about depression often result in stigma. Thus, having a mental illness results not only in trying to manage the debilitating symptoms of the disease, but additionally trying to protect oneself from the stereotypes, prejudice and discriminating experiences one faces in society due to their diagnosis (Corrigan, 2007; Rusch, Angermeyer, & Corrigan, 2005).

2.4.1 Stigmatization of Individuals with Mental Illness

In the United States, individuals with mental illness have been degraded, rejected, and subjected to prejudice and discrimination based on their mental health status (Crocker, Major & Steele, 1998). Research suggests that U.S. citizens, like most western nations, tend to sanction stigmatizing attitudes about the mentally ill (Link, 1987; Phelan et al., 2000; Corrigan & Watson, 2002). Further, research has documented that a large number of mental health professionals endorse negative stereotypes about mental illness (Lyons & Ziviani, 1995). Phelan and colleagues (2000) found that even though the general public seems to be more understanding and aware of mental illness than in the past, stigmatizing attitudes and beliefs about the dangerousness of persons with mental illness have become even more intense over the last few decades, particularly in regard to individuals with psychotic disorders (Newhill & Korr, 2004).

In addition to being associated more generally with negative attitudes, persons with mental illness tend to be represented in explicitly stereotypic ways (Corrigan, 1998). For example, individuals with mild mood disorders such as depression are often described as generally sick, worthless, and weak. Individuals with severe mood disorders and psychotic disorders are often described as dangerous, unpredictable, unsociable, and crazy (Socall & Holtgraves, 1992), and are portrayed in the mass media as unpleasant and violent (Arboleda-Florez, 2003). Sibicky and Dovidio (1985) found that stereotypes about the mentally ill are often activated spontaneously by the perceptions we have of individuals with mental illness. These stereotypic perceptions may persist even if the behavior of the individual in question does not justify such negative attributions. These beliefs can and often do lead to discriminatory actions when individuals with a mental illness attempt to seek employment (Farina & Felner 1973; Link, 1997) and housing (Page, 1995; Wahl, 1999).

Link and colleagues (2002) explain that people unconsciously develop negative perceptions and beliefs about mental illness very early in life through formal education, personal experience, and the media as a part of the socialization process. Based upon their negative perceptions of mental illness, people develop certain expectations as to whether they ought to devalue or reject an individual with a mental disorder, exert prejudice, and participate in discriminatory behavior. As social cognitive research suggests (Jones et al., 1984), the extent to which a condition is stigmatized appears to be a function, in part, of its visibility and controllability. In addition, stigma manifests itself in two distinct, yet overlapping ways – public stigma and internalized stigma.

2.4.2 Public Stigma

Public stigma refers to the negative beliefs, attitudes, and conceptions about mental illness held by the general population, which lead to stereotyping, prejudice, and discrimination against individuals with mental health disorders (Corrigan, 2002). In this conceptualization, public stigma also refers to the perception of the potentially stigmatized individual about how the public views individuals with mental illness. Sometimes, an individual's perception of public stigma about mental illness may be more critical than actual public beliefs, such that the individual may perceive society as being less accepting and more stigmatizing of mental illness than society actually is. However, it is often one's perception of stigma that impacts their attitudes and behaviors, despite the actual reality of a situation (Corrigan, 2002).

An individual's perception about society's attitudes and beliefs about his or her mental health status has been identified as a significant barrier to seeking help. Members of stigmatized and/or oppressed groups, such as individuals with mental illness, are generally aware of the negative stereotypes and attitudes that others have of them (Crocker, 1999). Roeloffs and colleagues (2003) found that 67% of their depressed participants expected negative consequences due to disclosure of depression on gaining employment, 59% for gaining health insurance and 24% on friendships. Due to concerns about the negative stereotypes associated with people diagnosed with a mental health disorder, a significant proportion of the people in need of psychological assistance may choose not to seek mental health treatment to avoid experiencing this stigma (Corrigan, 2002, 2004). Therefore, this label avoidance, utilized as a self-defense mechanism, may be the most significant way in which stigma impedes care seeking (Corrigan, 2004).

2.4.3 Internalized Stigma

Research on the stigma of mental illness has recently begun to address the internalization of stereotypes by stigmatized individuals. Internalized stigma refers to the devaluation, shame, secrecy, and social withdrawal, which are triggered by applying negative stereotypes about mental illness to self (Corrigan, 1998). Living in an environment which sanctions the stigmatization of people with mental illness, an individual with a mental health disorder may accept and internalize these stigmatizing attitudes and beliefs that appear to be endorsed within society (Corrigan, 1998; Link & Phelan, 2001). Individuals with mental illness may believe they have less value due to their membership within this stigmatized group, and may suffer negative emotional reactions, such as diminished self-esteem and self-efficacy, and self-imposed barriers to treatment seeking and treatment adherence.

In a sample of 82 adults at an outpatient unit of a Veteran Affairs Medical Center, Ritsher and Phelan (2004) found that a substantial proportion of the sample reported experiencing high levels of internalized stigma. This sample also had high perceptions of public stigma and subscribed to the belief that psychiatric patients are often devalued and discriminated against in society. Additionally, internalized stigma significantly predicted worsened depressive symptoms, controlling for the level of symptoms at baseline. Endorsing negative stereotypes about mental illness also predicted exacerbated depressive symptoms. Internalized stigma was also shown to predict reduced self-esteem. Interestingly, perceptions of public stigma were not significantly associated with reduced self-esteem, suggesting that internalization of stigma is the most psychologically devastating aspect of the stigmatizing experience.

2.5 THE IMPACT OF STIGMA

2.5.1 The Impact of Stigma on Mental Health Treatment

According to Cooper, Corrigan and Watson (2003), there is an inverse relationship between perceived public stigma and treatment seeking. Results of their survey indicated that members of the general public who blamed individuals for their mental illness and withheld help from them, were also less likely to seek help for themselves. Individuals who perceive society as holding stigmatizing beliefs about their mental illness are less likely to seek treatment than individuals who believe that society is generally accepting of individuals with mental illness. In a study examining the impact of perceived public stigma in a sample of 142 adults, Wrigley and colleagues (2005) found that high levels of perceived public stigma were significantly associated with negative attitudes toward seeking mental health treatment for depression. In a study examining the impact of stigma on treatment seeking in a sample of 1,312 randomly sampled adults, Barney and colleagues (2006) found that internalized stigma and perceived stigma about help-seeking for depression is common and that both types of stigma reduce the likelihood of help-seeking from any professional source. They found that the inhibitory effect of self-stigmatizing views was particularly strong. This finding supports other evidence that personal attitudes and internalizing stigma may be more important than the disapproval of others in predicting intentions to seek help from mental health professionals (Bayer & Peay, 1997).

Additional studies have shown an inverse relationship between perceived public stigmatizing attitudes and treatment adherence. Scores on the Perceived Devaluation and Discrimination Scale (Link et al., 1989) were associated with whether 134 adults were compliant with their anti-depressant medication three months later. Findings indicated that higher levels of

stigma were significantly related to reduced treatment adherence (Sirey et al., 2001). Sirey and colleagues (2001) found that client perception of stigma towards individuals with major depression predicted early treatment discontinuation in elderly patients. Sirey and colleagues (2001) also found that research participants who had major depression and expressed shame about their mental illness were significantly less likely to be involved in treatment. In a study of 490 primary care clients, Givens and colleagues (2007) found that stigma adversely affected the acceptability of mental health counseling.

Findings on these small samples have been supported by additional population-based studies. Results from the National Comorbidity Survey (Kessler, McGonagle, & Zhao, 2000) identified several specific beliefs that might deter individuals from seeking mental health treatment. These beliefs included concerns about what others might think (public stigma) and the view that one is personally responsible for one's condition, and therefore the notion that one should solve problems on one's own (internalized stigma). In a study of 1,187 depressed patients from 46 U.S. primary care clinics, Roeloffs and colleagues (2003) assessed perceptions of stigma and its perceived impact on a number of outcomes, including mental health treatment. Results indicated that perceptions of stigma were very high among depressed primary care patients. In this sample, perceived public stigma of having clinical depression was endorsed to a far greater degree than the stigma associated with both hypertension and diabetes. Stigma, as measured by an adapted version of Link's measures (Link et al., 1989) was not directly related to service use, but it was significantly correlated with unmet mental health care needs.

2.5.2 The Impact of Stigma Among African Americans

Historically, people of African descent in the United States have experienced stigmatization based on presumptions about their racial identity. In the case of double or multiple stigmas, African Americans with mental illness face the stigma of an additional taint, that of having a mental health condition which is also stigmatized. This interplay of race, stigma, and disease has been reflected in professional writings and in popular images throughout the 20th century, and the interrelation between group associated stigmas (race and aging) and disease associated stigmas (depression and mental illness) presents a compelling current medical, cultural and public policy dilemma (Wailoo, 2006). Due to experiencing multiple stigmas concurrently, African Americans who are also dealing with a mental illness endure discriminatory practices from multiple facets of society, which can have a deleterious impact on these individuals and their families (Gary, 2005).

Although past research has contributed significantly to our understanding of the stigma of mental illness, little empirical work has addressed the impact of stigma on attitudes toward treatment in African Americans. African Americans have been identified as a group that uses mental health services inconsistently (Brown & Palenchar, 2004) and is significantly less likely to utilize mental health services than their white counterparts (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen & Kendler, 1994). In a community sample, controlling for socio-demographic variables and diagnosis, Snowden (1999) found that African Americans were significantly less likely than white Americans to seek mental health services, attend fewer sessions when they do seek treatment, and are more likely than their white counterparts to terminate treatment prematurely, which supports the findings of Brown and Palenchar (2004). These findings suggest the importance of examining an overlooked, but salient barrier to mental health treatment for African Americans, such as stigma.

A number of structural and non-structural factors have been identified as significant barriers to mental health treatment for African Americans. Some structural barriers include: 1) lack of health care insurance, 2) lack of transportation and transportation difficulties, 3) lack of childcare offered at mental health facilities, 4) scheduling difficulties and 5) lack of access to mental health treatment (Grote, in press). Some non-structural barriers include: 1) racial/ethnic mismatch, 2) mistrust of service providers and helping organizations, 3) previous negative experiences with treatment, and 4) stigma (Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2000; Gary, 2005; Grote, in press). In addition, social attitudes and perceptions of mental health treatment significantly affect the help-seeking behaviors of African Americans (Diala et al., 2000). Utilizing a nationally representative sample, Diala and colleagues (2000) found that African Americans with more negative attitudes toward treatment were five times less likely to seek mental health services than individuals with more positive attitudes toward treatment.

Some empirical work suggests that the stigma of mental illness in the African American community may exert an adverse influence on attitudes toward mental health treatment and service utilization patterns by African Americans with a mental illness. An early study by Silva de Crane and Spielberger (1981) suggests that African Americans report more negative attitudes toward individuals with mental illness than their white and Hispanic counterparts. Cooper-Patrick and colleagues (1997) observed in their focus group discussions that African American participants raised more concerns regarding mental illness stigma than did white participants. Studies also show that African Americans are more likely to experience stigma about mental illness than their white counterparts. Rush (1998) found that participants assigned more stigma and blame to African American stigma targets than white stigma targets. Silva de Crane and Spielberger's (1981) study suggests that African American communities may be more stigmatizing in their

attitudes toward mental illness than white communities. These findings suggest that African Americans may experience more public stigma, and the negative effects of the stigma associated with mental illness may manifest themselves more intensely among African Americans than among whites, leading to more negative attitudes toward mental health treatment. To date, previous research has not addressed this important question.

2.5.3 The Impact of Stigma in Older Adults

As previously discussed, stigma and discrimination against older people with mental health disorders is a neglected problem in public health and social work research (Sartorius, 2003). The World Health Organization issued a statement on ‘Reducing stigma and discrimination against older people with mental health disorders’ (WHO, 2002), which validates the need for more research in this area. Stigma against the elderly combines two sets of interacting factors: 1) the socially imposed stigma of living with a mental health disorder, and 2) the negative societal perceptions of aging. Current attitudes toward older adults in the United States focus on a sense of weakness, frailty, and dependence. Decreased physical functioning due to the aging process or declining health and mobility likely contributed to the formation of these attitudes and beliefs. African American elderly with depression face multiple issues in society. These issues include the stigma of having a mental health disorder, being devalued in society due to their age, and trying to overcome the aforementioned barriers to mental health treatment that affect minority and older adult populations.

Stigma also impacts the help-seeking behaviors of older adults with depression. Despite the large number of the elderly in primary care, they are less often referred to secondary mental health services (Odell, Surtees, Wainwright, Commaner, & Sashidharan, 1997) and utilize these services

at much lower rates than their younger adult counterparts. (Manthorpe & Hettiaratchy, 1993). Katona and Livingston (2000) identify the stigma of mental illness as the most fundamental reason why elderly people choose not to seek mental health services. The Surgeon General's report on mental health (1999) highlighted stigma as a powerful obstacle to seeking care.

For the elderly, the effect of stigma on the use of mental health service use is especially severe (Depla, Graaf, Weeghel & Heeren, 2005; Sirey, Bruce, Alexopoulos, Perlick, Raue, Friedman, & Meyers, 2001; Leaf, Bruce, Tischler, & Holzer, 1987). Depla and colleagues (2005) found that 57% of their older respondents had experienced stigmatization about mental illness. They also found that experiences of being stigmatized were significantly associated with reduced quality of life. In this sample, the connection between stigma and negative quality of life was stronger than that between social participation and quality of life, which has significant implications for the impact of stigma in this population. In a sample of 92 mental health outpatient clients, Sirey and colleagues (2001) found that although younger people (aged 18-64) perceived more stigma than older people (aged 65 and older), perceived stigma towards individuals with mental illness predicted early treatment discontinuation in elderly patients with depression. No other demographic, clinical or treatment characteristics predicted drop-out in this study, which underscores the salient impact of stigma among older adults in this sample.

2.5.4 Summary

This chapter has highlighted the significance of the stigma associated with having a mental illness, and its impact on treatment seeking among older adults and racial minorities. This chapter also outlined a theoretical framework for stigma research and identified a number of empirical studies that validate the link between both public and internalized stigma and treatment seeking.

Despite this research, gaps in the literature persist. Research has not fully addressed the impact of the stigma associated with having a mental illness in aging populations, nor have scholars investigated the intersections of stigma associated with mental illness, race, and mental health treatment utilization. There is also a dearth of qualitative research that examines the experiences of stigma from the perceptions of individuals who have experienced being stigmatized due to depression, which is important in understanding the unique experiences of stigma among older adults. In addition, research has not sufficiently addressed the impact of stigma on individuals who are experiencing multiple stigmas simultaneously. The current study addressed these gaps in the literature by examining the relationships among stigma, race and treatment seeking attitudes and behaviors among depressed older adults.

3.0 METHODOLOGY

3.1 STUDY DESIGN AND SAMPLING STRATEGY

3.1.1 Design and Rationale

This dissertation study is a two-phase sequential mixed methods study. The first phase of the study involved a cross-sectional survey research design, and the second phase involved in-depth semi-structured interviews. Mixed methods research is formally defined as research that mixes or combines quantitative and qualitative research techniques, methods, approaches, or concepts into a single study (Creswell, 2003). Utilizing a mixed methods social work research design can aid researchers in answering a broader and more complete range of research questions, provide stronger evidence for a conclusion through convergence and corroboration of findings, and produce more complete knowledge necessary to inform theory and practice (Creswell, 2003).

In addition to these strengths, the rationale for utilizing a mixed methods approach is to answer questions that are unique to the population and cannot be captured with quantitative methods. It is important to validate the impact of the stigma associated with mental illness on treatment seeking among older adults, *why* there is an impact, and *why* there is a disproportionately negative effect on African Americans. It is necessary to explore in-depth individual perceptions and experiences with stigma in order for researchers and practitioners to

fully understand the way in which stigma is unique to older adults with depression. These questions are best addressed using qualitative analysis, where the researcher is able to study questions more in depth and access the true meaning behind research findings.

Additionally, it is important to address the issue of multiple, concurrent stigmas and how they interact to negatively affect treatment seeking. Currently, there is no accepted framework for the quantitative study of how multiple stigmas interact to affect specified outcomes (Crandall, 1991). However, experiencing multiple, concurrent stigmas may help to explain why older African Americans tend to perceive more mental illness stigma than their white counterparts. The qualitative phase of this study adds to the body of knowledge focusing on mental illness stigma, and substantially builds upon my work in the quantitative phase of this study. Initially exploring the impact of experiencing multiple, concurrent stigmas qualitatively provides an in-depth look at this issue and aids in the identification and development of a framework for exploration that can be tested in a large-scale quantitative study in the future.

3.1.2 Sampling Strategy

This study utilized random digit dialing (RDD) telephone sampling methodology to obtain a representative sample of a total of 248 respondents (120 African American and 128 white older adults) living in Allegheny County, Pennsylvania. Eligible study respondents included men and women age 60 years and older who: (a) were English speaking; and (b) reported at least mild to moderate symptoms of depression according to the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001). Exclusion criteria included: (a) mood symptoms within the normal range; (b) bipolar depression; and (c) current substance abuse/dependence within the past six months.

3.2 PROCEDURES FOR SAMPLING AND COLLECTING DATA

3.2.1 Phase One: Survey

In phase one, survey interviews were conducted over the phone by the University Center for Social and Urban Research (UCSUR) at the University of Pittsburgh using random digit dialing (RDD) telephone sampling methodology. UCSUR is a well-established survey research program that has extensive experience conducting telephone surveys with older adults using RDD (See Appendix F). Random digit dialing (RDD) is identified as the most statistically valid method of telephone sampling (Cummings, 1979). This sampling methodology gives all telephone numbers including cell phones (both listed and unlisted) an equal chance of being selected, thus reducing sampling bias and resulting in a representative and population-based sample of older adults in Allegheny County, PA.

The study protocol required a sample of 248 older adults (120 African American and 128 white) residents of Allegheny County; therefore, a stratified RDD sampling approach was employed to ensure the correct number of racial groups were represented in this sample. Utilizing this random digit dialing procedure, county area code/telephone exchange combinations were divided into two strata: (1) exchanges with less than 25% estimated African American population (the low-density African American stratum), and (2) exchanges with an estimated 25% or higher African American population (the high-density African American

stratum). Random samples of telephone numbers from the two strata were then selected for quantitative telephone interviews. Interviews were conducted with African Americans from the high-density strata and with whites from the low-density strata. This approach increased efficiency and thus reduced costs, while maintaining the ability to generate population-based estimates.

The survey was conducted using UCSUR's computer-assisted telephone interviewing (CATI) standardized data collection protocol. CATI surveys involve programming the survey using specialized software, with the interviews conducted at personal computers, which display the questions in proper order and automatically control question skip and flow patterns. The CATI system also has sample management and call scheduling routines built in. This technology eliminates the need for paper call records and allows the interviewers to concentrate on conducting high quality interviews. Interviewers were trained in basic and project-specific interviewing techniques, and were continuously monitored for quality assurance.

In order to maximize response rates, at least 12 calls were made on varying days of the week at different times to increase the probability of contacting respondents. The interview consisted of an initial screener for eligibility (the PHQ-9 depression inventory), followed by the remainder of the interview for those screened as eligible. The remainder of the interview contained questions regarding respondents' mental health status, their perceptions of mental illness stigma, their attitudes toward mental health treatment, their intention to seek treatment, and their current or previous engagement in mental health treatment (See Appendix A for the sample survey protocol).

In order to achieve this sample, an extremely labor intensive effort was required. A total of 63,557 telephone numbers were processed, and nearly 200,000 actual dialings were required

(198,599). The majority of this effort was dedicated to the high density African American strata in order to achieve the required 50/50 racial quota for the sample. The outcomes for all telephone numbers in the sample are summarized next, separately for the high density and low density African American strata. In the high density strata, a total of 55,016 numbers were used resulting in 340 completed interviews (43 Whites under age 60; 86 Whites 60 and older; 95 African-Americans under 60; 116 African-Americans 60 and older). The remainder of the high-density sample was distributed as follows: 60 eligible participants refused to complete the full interview; 4,075 refused to be screened (7.4%); 15,714 no contact after multiple attempts (28.6%); 10,006 race- or age-ineligible (18.2%); 1,140 depression-ineligible (2.1%); 158 bipolar disorder/alcohol ineligible (0.3%); and 23,523 ineligible non-households (non-working, businesses, etc.; 42.8%). In sum, approximately 37% of the high-density strata households were successfully screened (eliminating non-households), and 85% of those determined to be eligible completed the full interview.

In the low density strata, a total of 8,541 numbers were used resulting in 109 completed interviews (58 Whites under age 60; 42 Whites 60 and older; 5 African-Americans under 60; 4 African-Americans 60 and older). The remainder of the low-density sample was distributed as follows: 6 eligible participants refused to complete the full interview; 1,946 refused to be screened (22.8%); 2,703 no contact after multiple attempts (31.6%); 733 race- or age-ineligible (8.6%); 275 depression-ineligible (3.2%); 32 bipolar disorder/alcohol ineligible (0.4%); and 2,737 ineligible non-households (32.0%). Approximately 20% of the low-density strata households were successfully screened (eliminating non-households), and 95% of those determined to be eligible completed the full interview.

In summary, across both high- and low-density strata, 34.4% of households were successfully screened (12,859 total screened households), and 87.2% of those determined to be eligible completed the full interview. It should be noted that many of the no contact phone numbers may not actually be households, and thus the household screening success rate is actually somewhat higher. Each phone interview took approximately one-half hour to complete.

3.2.2 Phase Two: Interviews

Out of the total sample of 248 older adults, there were 120 older African Americans. Out of the 120 older African Americans who completed the initial telephone survey, 84 stated that they would be willing to be contacted in the future to participate in an in-depth semi-structured interview (See Appendix C for telephone script). In preparation for the interviews, the lead researcher utilized a random numbers chart (Rubin and Babbie, 2005) to select 40 African American older adults to be contacted. Participants were either contacted by the lead researcher, or by a second licensed master's level social worker trained by the lead researcher. This licensed social worker conducted 10 of the 20 interviews, after first shadowing the lead researcher on two interviews. When the interview participants were contacted, they were reminded of the original telephone survey they had completed, and of their statement of willingness to be contacted for an additional in-person interview. Out of the original 40, eight telephone numbers had been disconnected, six people chose not to participate in this phase of the study and the other six were unable to be reached. Twenty interviews were completed in participants' homes, and all lasted between 30 minutes and 90 minutes. All participants received thirty dollars for their time. While there is no "gold standard" for an appropriate sample size in qualitative research, in practice 12-26 in-depth interviews is acceptable (Luborsky & Rubinstein, 1995). Therefore, this researcher

chose to conduct a minimum of 20 interviews, and planned to continue to conduct up to 26 interviews (utilizing the random numbers chart to select an additional group of participants to be contacted) if the initial 20 did not yield saturation and new interviews continued to yield new information.

Before beginning the qualitative interviews, participants completed a demographic questionnaire and re-completed the Patient Health Questionnaire (PHQ-9). Participants in the first phase of the study needed to endorse at least mild symptoms of depression; therefore, all participants who were contacted were eligible to participate in the in-depth interviews, even if their PHQ-9 scores had decreased over time. The in-depth interviews contained questions about respondents' experiences with and perceptions of stigma, and its impact on their treatment seeking attitudes and behaviors (e.g. 'has stigma affected your decisions about seeking treatment' and 'do you believe your age and/or race affects your perceptions of stigma'). The qualitative phase of this dissertation study specifically addressed the impact of experiencing multiple, concurrent stigmas (e.g. mental illness, age, and minority racial status) on the treatment seeking attitudes and behaviors of older African Americans. Additional questions also examined other potential barriers to care. (See Appendix B for semi-structured interview protocol).

The interviews were digitally audio taped and subsequently transcribed verbatim. The Qualitative Data Analysis Program (QDAP) at the University of Pittsburgh Center for Social and Urban Research (UCSUR) transcribed the 20 interviews. At 20 interviews, there was saturation of data in that the interviews no longer yielded new information. Therefore, the researcher concluded the current study with a total of 20 interviews.

3.2.3 Study Variables and Measurement

Demographic Variables:

Self-reported demographic information obtained included age, marital status, gender, education, employment status, income and self-reported mental health status.

Independent variable:

This researcher utilized respondents' self-report of their racial and ethnic minority background to measure the independent variable of race. Race is an appropriate independent variable in that it has been identified as a significant predictor of certain treatment seeking attitudes and behaviors (Snowden, 2001).

Dependent Variable (1):

'Attitudes Toward Mental Health Services' was assessed utilizing the Attitudes Toward Mental Health Treatment Scale (ATMHT). The ATMHT is comprised of 20 items with a four-point Likert scale, and is intended to reflect an individual's attitude toward professional mental health treatment. For the purpose of this study, a modified version of the 29 item Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970) was used. Despite its utility and vast usage, several conceptual and methodological concerns have been raised regarding the language and cultural appropriateness of the ATSPPHS. To address these concerns, this researcher adapted this scale to include more culturally relevant language and items. Higher scores indicate more positive attitudes about seeking mental health treatment. This scale was utilized with a racially diverse community-based sample of older adults (Conner,

2006). Preliminary reliability tests of the ATMHT have been positive, as it demonstrated high internal consistency with a Cronbach's alpha = 0.95.

Dependent Variable (2):

'Engagement in Mental Health Treatment' was assessed with 3 questions. The first question asked, "At any time in the past, have you ever visited a mental health professional (psychiatrist, psychologist, social worker, mental health counselor, or primary care physician for a problem with your emotional or mental health (yes or no)?" If yes, "When was your most recent visit? Within the past month, 1-6 months ago, 7-12 months ago, more than 12 months ago." A third question asked: "Are you currently receiving treatment for depression (yes or no)?"

Dependent Variable (3):

'Intention to Seek Treatment for Depression' was assessed with one item: "During the next month, I intend to speak or meet with a health professional to discuss my symptoms of depression." Respondents indicated on a 5-point scale (extremely unlikely to extremely likely) the likelihood of engaging in this behavior.

Potential Mediator Variable (1):

'Public stigma' was assessed utilizing the Perceived Devaluation and Discrimination Scale (PDD; Link, 1982). This 12-item, four-point Likert scale, evaluates the extent to which a person believes that other people will devalue or discriminate against someone with a mental illness.

Higher scores indicate higher levels of public stigma. This scale was successfully utilized with a sample of older adults in a preliminary study (Conner, Koeske, & Brown, 2006). The PDD demonstrates high internal consistency with estimates ranging from .82 to .93 and demonstrates good construct and predictive validity (Link, 1982; 1989). For the current investigation, the scale was revised and items referred to having ‘had depression’ rather than ‘having been treated for a mental illness.’ The rationale for this revision suggested that views about severe mental illnesses and depression might differ and, therefore, it was necessary to distinguish between the two terms and dissociate treatment for a mental illness from the presence of depression. The psychometrics for the revised PDD scale are reported in the study results (see chapter four).

Potential Mediator Variable (2):

‘Internalized stigma’ was assessed utilizing the Internalized Stigma of Mental Illness Scale (ISMI) (Ritsher, Otilingam, & Grajales, 2003). Distinct from other stigma scales, which focus on social attitudes toward the mentally ill or perceptions of these attitudes, the ISMI focuses on the individual’s subjective experience as someone with a mental illness. The ISMI contains 29 items rated on a four-point Likert scale, and assesses alienation, stereotype endorsement, perceived discrimination, social withdrawal, and stigma resistance. Higher scores indicate higher levels of internalized stigma. This scale was successfully utilized with a sample of older adults in a preliminary study (Conner, Koeske, & Brown, 2006). The ISMI demonstrates excellent internal consistency reliability estimates ranging from .88 to .94 and demonstrates good construct and predictive validity (Corrigan, 2004; Ritsher et al., 2003). For the current investigation, the scale was revised and items referred to having ‘had depression’ rather than ‘having a mental illness.’ The rationale for this revision was that views about severe mental illnesses and depression might

differ and, therefore, it was necessary to distinguish between the two terms. The psychometrics for the revised ISMI scale are reported in the study results (see chapter four).

Clinical Characteristics:

The Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer, & Williams, 2001) was used to characterize severity of the depressive symptoms, existence of clinically significant depressive symptoms, and presence of current psychosocial impairment. The PHQ-9 has been used extensively to examine depression symptoms and has been successfully utilized with both older adult populations and African Americans (Oslin et al., 2006). Cut-points have been established that correspond to minimal (*score 1-4*), mild (*score 5-9*), moderate (*score 10-14*), moderately severe (*score 15-19*), and severe (*score 20-27*) symptom levels and algorithms developed to establish depressive disorder diagnoses. Anyone who received a score of 5 and above was eligible to participate in this study. Any participant who scored a 10 or above on the PHQ-9, or who requested a referral, was referred for treatment at Western Psychiatric Institute and Clinic (WPIC) or at the participant's local community mental health center. To minimize risk of suicide, if a respondent endorsed the suicide item # 9 on the PHQ-9 (e.g., 'thoughts of harming oneself') the call was handed over to a trained supervisor at UCSUR who assessed the severity of the suicidal ideation, assessed imminent risks, and implemented a referral for evaluation at Western Psychiatric Institute and Clinic.

3.3 DATA ANALYSIS PLAN

3.3.1 Quantitative Data Analysis

Descriptive and Univariate Analyses.

This researcher conducted descriptive analyses to characterize the sample's demographic variables. Racial differences in demographic variables were examined using either *t*-tests or Chi Squares. In addition, analyses of the study variables of interest by racial group were conducted to 1) to examine measures of central tendency (mean, median, and mode) and measures of dispersion (standard deviation, range, and skewness); and 2) to observe the extent of support for the following hypotheses related to racial differences: H1a, H1b, H1c, H2a, and H2b. *t*-tests were utilized to examine racial differences in score variables, which chi squares were utilized to examine racial differences in categorical variables, relevant to current or previous engagement in mental health treatment. In addition, the results of the univariate analyses were examined for the normality of distribution of study variables, and to assess the need to correct for skewness using transformations. Further, the results were used to assess the need for recoding, merging, collapsing and dummy-coding in order to develop parsimonious multivariate models.

Bivariate Analyses.

Zero-order correlations were calculated for study variables of interest to identify the strength, direction, and significance of associations between study variables. The particular focus of examination was on the relationships among the independent or predictor variables, potential mediating variables, and the dependent variables to test the following hypotheses: H3a, H3b, and H3c.

Multivariate Analysis.

To test Hypotheses 4a, 4b and 4c (stigma partially mediates the relationship between race and treatment seeking attitudes and behaviors), path analysis and simultaneous multiple regression procedures were conducted. Before the analysis, the data were tested for assumptions of multiple regression, including the absence of outliers and multi-collinearity, homoscedasticity of residuals, and independence of error terms. Following the procedure of Baron and Kenny (1986), four regression equations were conducted for each dependent variable (attitudes toward treatment, intention to seek treatment, and engagement in treatment). The first regression model was utilized to determine the direct association between the predictor variable (race) and the criterion variables (attitudes/intentions/engagement). The second regression model examined the relationship between the predictor variable (race) and the mediating variables (public and internalized stigma). The third regression model examined the relationship between the mediating variables (public and internalized stigma) and the criterion variables (attitudes/intentions/engagement). The final regression models determined whether statistical significance of race on mental health treatment seeking attitudes and behaviors was reduced when both public and internalized stigma were added to the analysis.

Power Analysis.

An important consideration in conducting survey research is whether the sample size in the proposed study will have adequate power in rejecting a null hypothesis or if it has enough power to detect a statistically significant effect (Cohen, 1988). Using the SPSS Sample Power Analysis Program (Cohen, Borenstein & Rothstein, 2000), a power analysis was conducted to examine the adequacy of power in a sample size of 248 for multiple regression analysis, the multivariate statistical analysis method planned for the proposed study. The power analysis indicated that a

sample size of 248 would have the power to detect a small effect size of .10 attributed to three independent variables and significance levels of alpha .05. Therefore, the sample size of 248 in this dissertation study was far above the required level of power needed (80%) to achieve rejection of a false null hypothesis (Cohen, 1988).

3.3.2 Qualitative Data Analysis

Thematic Analysis.

With respect to the qualitative data in phase 2 of the proposed study, the primary analytic approach utilized was theme-based content analysis of the interview transcriptions using the ATLAS.ti qualitative data analysis program. Themes pertaining to the impact of experiencing multiple, concurrent stigmas were examined to address Question 4. There were four steps involved in the thematic analysis of the qualitative data. First, audiotapes from the qualitative interviews were collected and transcribed verbatim. Second, transcripts were in vivo (line-by-line) coded utilizing respondents' own language and meanings to represent their statements (Strauss & Corbin, 1990). Third, using ATLAS.ti (See Appendix E for description), individual codes of data were entered into this computer program to facilitate qualitative thematic analysis. Patterns of codes were combined to form categories of data, which were expanded into sub-themes and finally into broad themes. Themes are defined as units of information derived from patterns such as conversation topics, vocabulary, meanings, feelings, and proverbs and bring together components or fragments of ideas or experiences, which often are meaningless when viewed alone. To provide inter-rater reliability, this researcher independently coded the data and subsequently met with the licensed social worker who conducted half of the interviews to discuss

themes and reach consensus. Additionally, the qualitative results were triangulated with the quantitative findings, which provide additional validation for the study findings.

3.3.3 Integration of Quantitative and Qualitative Data

In the final stage of data analysis, themes that emerged from the respondents' interviews were integrated with the results of the quantitative data analyses to form a comprehensive picture of their collective experience with stigma. The findings from the two methodologies were examined again in parallel to cross-validate and build upon each other's results. The integration of the quantitative and qualitative research data lent depth and clarity to the overall findings and implications of this dissertation study, which has helped to inform relevant research, practice, policy and theory, and substantially contributes to the geriatric social work knowledge base. This integration will be presented in the discussion section.

3.3.4 Human Subjects Review

An introduction to the study was conducted over the telephone by the UCSUR interviewers, which provided information about the purpose of the study, the voluntary nature of the study, and the right of the individual to refuse to answer any question at any point in time. Risks to respondents might have included emotional discomfort when talking about emotionally sensitive topics, and they might have felt worse after talking about their mental health concerns. However, all UCSUR assessors were experienced in interviewing and made every effort to conduct interviews in a sensitive and supportive manner. Recruitment of an additional 20 older African Americans for in-

depth qualitative analysis was conducted according to Institutional Review Board (IRB) standards (See Appendix C for telephone script). Potential respondents were informed that their participation in these interviews was completely voluntary and that they could refuse to participate or answer any question at any time. They also received and signed an informed consent form during their interview.

The only direct benefits to respondents for participating in this dissertation study were a depression assessment and treatment referral provided at no charge. Any participant who scored a 10 or above on the PHQ-9 or who requested a referral was referred for treatment at Western Psychiatric Institute and Clinic (WPIC) or at the participant's local community mental health center. To minimize risk of suicide, if a respondent endorsed the suicide item # 9 on the PHQ-9 (e.g. several times 'thoughts of harming oneself') the call was handed over to a trained supervisor at UCSUR who assessed the severity of the suicidal ideation, assessed imminent risks, and implemented an immediate referral for further evaluation at Western Psychiatric Institute and Clinic (WPIC), or immediate psychiatric hospitalization via emergency services when necessary. Participants were compensated for their time-- \$15 for the telephone interview and \$30 for the in-depth semi-structured interview. To address confidentiality and anonymity, a secure server was used to store data, findings were reported in statistical terms so that no individuals could be identified, and qualitative data was reported with the use of pseudonyms. Due to the necessity of collecting addresses from respondents to send them their \$15 payment, even though procedures are in place to separate all identifying information from survey responses, this researcher underwent the expedited IRB process at the University of Pittsburgh and the committee approved this study on September 1, 2006.

4.0 RESULTS

Due to the explanatory sequential mixed methods design of the research study, quantitative results will be presented first. The analysis is presented first through simple statistics (e.g., measures of central tendency), then through measures of relationships (i.e. correlations) and then inferential methods (i.e. multiple regression analysis) to allow readers an understanding of the constructs of interest. Following a brief section outlining some additional interesting findings, qualitative results are presented. Qualitative results are presented according to the relevant themes identified in the data, and exemplar participant quotes are utilized to highlight the appropriate theme. Finally, quantitative and qualitative findings are synthesized and integrated in the discussion section. This provides the reader with a thorough understanding of these 20 older African Americans' experiences with depression, mental health treatment, and stigma.

Data collection and electronic input of the quantitative data was conducted by the University Center for Social and Urban Research (UCSUR), and 10 semi-structured interviews were conducted by a licensed social worker trained by this researcher. However, the majority of qualitative data collection, and all coding and electronic input were conducted by this researcher. Additionally, this researcher performed all data analysis in order to ensure uniformity across the study design.

4.1 QUANTITATIVE RESULTS

A total of 248 surveys were completed. Data from the demographic form, the Attitudes Toward Mental Health Treatment Scale (ATMHT), the Perceived Devaluation and Discrimination Scale (PDD) and the Internalized Stigma Scale (ISMI) were scored and then entered into SPSS. Means, standard deviations, and ranges were calculated. In order to maximize the N, the researcher utilized mean imputation, which allowed for the data set's inclusion in the analyses. Mean imputation is the most straightforward and commonly used method for handling missing data (Allison, 2001; Newton & Rudestam, 1999). Mean estimation is a conservative procedure, in that the mean distribution of the variable does not change. Mean imputation was conducted in SPSS utilizing the series mean after determining that the missing data were Missing at Random (MAR), a condition which exists when missing values are not randomly distributed across all observations, but are randomly distributed within one or more sub-samples. This researcher conducted all analyses with the original data utilizing a listwise deletion of missing cases, as well as with mean imputation, to determine whether there were significant differences in the findings based upon utilization of this method for missing data. Despite some minor reductions in the correlations of the study variables, there were no significant differences. Therefore, the data presented in this section are mean imputed data.

4.1.1 Preliminary Analysis

Means, standard deviations, skew, and kurtosis statistics for all of the main study variables and scales were calculated and reported in Table 1. Skew and kurtosis values for all the main variables and scales were close to the cut point of .80. However, the intention to seek mental

health treatment variable had a skew of -1.37 . Therefore, a square root transformation was conducted, which reduced the skew to an acceptable $.388$. The currently in treatment variable is a dichotomous variable, and therefore unable to be transformed. All of the other study variables met the assumption of normality and were appropriate for statistical analysis utilizing planned parametric statistics. To examine the internal consistency reliability of the study's main scales, reliability analysis was conducted. Cronbach's alpha coefficients were calculated for the three main study scales including the Perceived Devaluation and Discrimination Scale (PDD), Internalized Stigma of Mental Illness Scale (ISMI), and the Attitudes Toward Mental Health Treatment Scale (ATMHT). The Cronbach's alpha coefficients are also presented in Table 1. The reliability estimates for all three of these scales were above $.70$, suggesting acceptable internal consistency. Estimates of internal consistency utilized in this study were comparable to those reported by the authors of the instruments.

Table 1. Descriptive Statistics for the Main Study Scales and Variables

Variable	Mean	SD	Skew	Kurtosis	α
Age	71.7	7.89	.289	-.810	
Public Stigma	2.60	.332	.523	1.109	.74
Internalized Stigma	2.14	.362	-.081	.335	.93
Attitudes Treatment	2.76	.259	.577	1.22	.75
Intentions Treatment	1.78	.414	-.388	-.813	

4.1.2 Sample Characteristics and Descriptive Analyses

Through random digit dialing data collection technique, 248 adults met inclusion criteria for the study and completed the telephone survey. There were 120 African Americans (51.6%) and 128 whites (48.4%). Eighty four percent of the sample was female (n=207). Participants' age ranged from 60 years to 93 years old, with a mean age of 72 (SD= 7.8). Forty percent of the sample was widowed (n= 112), with the additional 42% either married (n= 54) or divorced (n= 49). Sixty-seven percent of the sample participants were high school graduates (n= 82), had a GED equivalent (n= 13) or had completed at least some college (n= 73), and 81% (n= 201) of the sample participants were retired.

The majority of participants (73%) scored between 16 and 22 on the Patient Health Questionnaire (PhQ-9). These scores indicate moderate to severe depression symptoms. Despite high rates of depression symptoms, more than half of study participants (56%) had never seen a mental health professional for treatment. For those 106 participants who had sought mental health treatment, sixty percent (n= 63) stated that their most recent visit to a mental health professional was over 12 months ago. Less than 16% of participants were currently in treatment for depression. Additionally, only 18% stated that they were likely to seek mental health treatment in the future, with 82% of study participants stating that they were unlikely, extremely unlikely, or unsure about seeking mental health treatment in the future.

There were also some interesting differences by race on these basic characteristics. Not surprisingly, African Americans in this sample were more likely to be less educated, earn less yearly income, and have a full- or part-time job than their white counterparts. Interestingly, African American and white participants had similar PHQ-9 scores, indicating similar levels of depressive symptoms, which is consistent with current literature. However, while more than 50%

(n= 67) of the white participants stated that they had seen a mental health professional in the past for treatment, more than two-thirds of the African American sample (n= 81) stated that they had never seen a mental health professional for treatment. Additionally, there were fewer African Americans currently in treatment for their depression (n= 16) than their white counterparts (n= 23).

Table 2. Sample Demographic Characteristics

Characteristics	Total Sample (n = 248)	Black (n= 120)	White (n= 128)
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Gender:			
Female	207 (16.5)	102 (85.0)	105 (82.0)
Male	41 (83.5)	18 (15.0)	23 (18.0)
Age:			
60 - 70 years	117 (47.2)	67 (55.8)	50 (39.1)
71- 80 years	88 (35.4)	36 (30.0)	52 (40.6)
81- 90 years	42 (16.9)	16 (13.3)	26 (20.3)
90+ years	1 (0.5)	1 (.08)	0 (0)
Education:			
Less than high school	5 (2)	6 (12.5)	1 (.9)
Some high school	27 (10.9)	14 (29.2)	7 (6.1)
High school graduate	95 (38.3)	14 (29.2)	52 (45.2)
Some college	73 (29.4)	8 (16.7)	38 (33.0)

College graduate	25 (10.1)	4 (8.3)	17 (14.8)
Marital Status:			
Single, never married	23 (9.3)	6 (5.0)	17 (13.3)
Married	54 (21.8)	16 (13.3)	38 (29.7)
Divorced	49 (19.8)	29 (24.2)	20 (15.6)
Widowed	112 (45.2)	62 (51.7)	50 (39.1)
Employment:			
Full-time	19 (7.7)	11 (9.2)	8 (6.3)
Part-time	23 (9.3)	12 (10.0)	11 (8.6)
Retired	201 (81.0)	95 (78.3)	107 (83.6)
Unemployed	5 (2.0)	3 (2.5)	2 (1.6)
Income:			
Less than \$10,000	47 (19.0)	32 (28.1)	15 (12.2)
\$10,000 to \$19,999	79 (31.9)	41 (36.0)	38 (30.9)
\$20,000 to \$34,999	43 (17.3)	20 (17.5)	23 (18.7)
\$35,000 to \$49,999	27 (10.9)	7 (6.1)	20 (16.3)
\$50,000 to \$74,999	20 (8.1)	7 (6.1)	13 (10.6)
More than \$75,000	6 (2.4)	0 (0)	6 (4.1)

Table 3. Sample Clinical Characteristics

Characteristics (Level)	Total Sample (n= 248) n (%)	Black (n= 120) n (%)	White (n= 128) n (%)
PhQ9 Score:			
13-14(<i>mild</i>)	4 (1.6)	1 (.8)	3 (2.3)
15-19(<i>moderate</i>)	125 (50.4)	62 (51.7)	63 (49.2)
20-27(<i>moderate/severe</i>)	103 (41.5)	51 (42.5)	52 (40.6)
28+ (<i>severe</i>)	16 (6.5)	6 (5.0)	10 (7.8)
Ever in Treatment:			
Yes	106 (42.7)	39 (32.5)	67 (53.6)
No	139 (56.0)	81 (67.5)	58 (46.4)
Most Recent Treatment (n=106)			
Within the past month	10 (9.4)	3 (7.7)	7 (10.4)
1 to 6 months ago	23 (21.7)	13 (33.3)	10 (14.9)
7 to 12 months ago	10 (9.4)	6 (15.4)	4 (6.0)
More than 12 months ago	63 (59.4)	17 (43.6)	46 (68.7)
Currently in Treatment:			
Yes	39 (15.7)	16 (13.3)	23 (18.1)
No	208 (83.9)	104 (86.7)	104 (81.9)

4.1.3 Bivariate Analysis

Independent sample *t* tests and Chi Square Tests were conducted to assess mean differences on dependent variables by racial group and to answer two research questions: 1) Do attitudes and behaviors toward seeking mental health treatment differ by race among older adults with depression; 2) Do perceptions of and experiences with mental illness stigma differ by race? For the following analyses, the assumptions of normality and homogeneity of variance were met.

H.1a: African American older adults have less positive attitudes toward seeking mental health services than their white counterparts. An independent sample *t* test, using race as the grouping variable and the Attitudes Toward Mental Health Treatment (ATMHT) scale score as the test variable, was utilized to test this hypothesis. As predicted, older African Americans ($M=2.72$, $SD=.18$) had significantly lower scores on the ATMHT scale as compared to their older white counterparts ($M=2.79$, $SD=.17$), suggesting that the older African Americans in this sample endorse less positive attitudes towards mental health treatment $t(246)=2.790$, $p<.00$. The correlation between race and attitudes toward seeking mental health treatment is also significant $r=.175$, $p<.01$. Despite the significant difference between the racial groups, both older African American and white sample participants' mean scores reflect both positive and negative attitudes toward seeking mental health treatment.

H.1b: African American older adults are less likely to intend on seeking mental health services than their white counterparts. An independent samples *t* test, using race as the grouping variable and intention to seek mental health treatment as the test variable, was conducted to test this hypothesis. Contrary to prediction, there were no significant differences by race on intentions toward seeking mental health treatment $t(245)=-.779$, $p>.05$. Older African Americans ($M=1.87$, $SD=.429$) endorsed very similar intentions toward seeking mental health

treatment as compared to their white counterparts ($M= 1.82$, $SD= .402$). The correlation between race and intention toward seeking mental health treatment was not significant ($r = .050$, $p>.05$). Both older African Americans and older whites had low intention toward seeking mental health treatment in the near future.

H.1c: African American older adults are less likely to be engaged in mental health services than their white counterparts. Chi Square tests, using race as the independent variable and current engagement in mental health treatment and having ever been engaged in mental health treatment as the dependent variables, were conducted to test this hypothesis. Currently engaged in mental health treatment was recoded for this analysis (Currently in treatment= 1 and not in treatment= 2). Contrary to prediction, there were no significant differences by race on current engagement in mental health treatment $\chi^2(1, N=248) = 1.06$, $p>.05$. The Pearson correlation between race and engagement in mental health treatment was also not significant (r point-biserial = $.065$, $p>.05$). Both African American and white older adults were not likely to currently be engaged in mental health treatment. However, there were significant differences by race on having ever sought mental health treatment $\chi^2(1, N=248) = 11.1$, $p<.00$. The Pearson correlation between race and having ever been engaged in mental health treatment was also significant (r point-biserial = $.21$ $p<.01$). African Americans were significantly less likely to have ever sought mental health treatment as compared to their white counterparts.

H.2a: African American older adults perceive more public stigma⁶ about mental illness than their white counterparts. An independent samples t test, using race as the grouping variable and the Perceived Devaluation and Discrimination (PDD) scale score as the test variable, was utilized to test this hypothesis. Contrary to prediction, there were no significant differences by

⁶ Public stigma refers to negative perceptions of how the public views people with a mental illness.

race on perceptions of public stigma $t(246) = -.58, p > .05$. The correlation between race and public stigma was also not significant ($r = .03, p > .05$). Older African Americans ($M = 2.61, SD = .28$) endorse similar scores on the PDD scale as compared to their older white counterparts ($M = 2.59, SD = .29$), suggesting that the perceptions of stigma among the samples older participants are comparable. The mean scores of both the older African American and white participants also suggest that the perceptions of public stigma are high for both groups.

H.2b: African American older adults experience more internalized stigma⁷ about mental illness than their white counterparts. An independent samples t test, using race as the grouping variable and the Internalized Stigma of Mental Illness (ISMI) scale score as the test variable, was utilized to test this hypothesis. As predicted, older African Americans ($M = 2.18, SD = .30$) had significantly higher scores on the ISMI scale as compared to their older white counterparts ($M = 2.10, SD = .31$), suggesting that the older African Americans in this sample endorse more internalized stigma $t(246) = -2.118, p = .035$. The correlation between race and internalized stigma was significant ($r = .134, p = .035$). Despite the significant difference between the racial groups, both older African American and white sample participants' mean scores reflect moderately high levels of internalized stigma. Interestingly, an independent samples t test found that there were significant differences on the internalized stigma scale by gender. Men ($M = 2.25, SD = .30$) had significantly higher internalized stigma scores as compared to women ($M = 2.11, SD = .30$) in the sample $t(246) = 2.46, p = .014$. The correlation between gender and internalized stigma was also significant ($r = -.155, p < .05$).

Pearson correlations were utilized to examine the associations between main study variables (race, attitudes toward mental health treatment, internalized stigma, public stigma,

⁷ Internalized stigma refers to the application of negative stereotypes about mental illness to oneself.

intention to seek treatment, current engagement in treatment and age) clinical variables (PhQ-9 score) and possible covariates (gender, income and education). Correlations were utilized to answer the following question: To what extent does mental illness stigma relate to the treatment seeking attitudes and behaviors of older adults with depression?

In the analysis education and age were significantly related to race, such that African Americans in the current sample were more likely to be younger and less educated than their white counterparts. As such, these variables were considered possible covariates and were controlled in multivariate analysis. As shown in Table 4, Pearson correlations identified a negative relationship between race and attitudes toward mental health services ($r = -.175, p < .01$). This suggests that being an African American is related to having more negative attitudes toward mental health treatment. There was also a significant positive association between race and internalized stigma ($r = .134, p < .05$). This suggests that being an African American is related to higher levels of internalized stigma. The relationship between race and public stigma was not statistically significant ($r = .037, p > .05$). These results were similar even when broken down by race and across race.

H.3a: High perceptions and experiences of internalized and public stigma will be related to more negative attitudes toward treatment for both African American and white older adults. Pearson correlations were utilized to test this hypothesis. As predicted, internalized stigma ($r = -.25, p < .01$) was significantly negatively correlated with attitudes toward seeking mental health services. This suggests that having high levels of internalized stigma is related to having more negative attitudes toward mental health treatment. The correlation between public stigma and attitudes toward mental health treatment was not significant ($r = -.05, p > .05$). While this statistic suggests that individuals with high levels of public stigma were also more likely to have negative

attitudes about mental health treatment, this relationship was not statistically significant. The relationship between public stigma and attitudes toward treatment was extremely non-significant when broken down by race.

H.3b: High perceptions and experiences of stigma will be related to reduced intention to seek mental health treatment for both African American and white older adults. Pearson correlations were utilized to test this hypothesis. As predicted, internalized stigma ($r = .136$, $p < .05$) was significantly correlated with intention toward seeking mental health services, but not in the expected direction. This data suggests that having high levels of internalized stigma is related to more intention toward seeking mental health treatment. There was no significant correlation between public stigma and intention to seek mental health treatment ($r = -.006$, $p > .05$).

H.3c: Older adults who perceive and experience high amounts of stigma will be less likely to be engaged in mental health treatment than those who perceive low stigma. Pearson correlations were utilized to test this hypothesis. Contrary to what was predicted, there were no significant correlations between internalized or public stigma and current engagement in mental health treatment. There was a trend in the unexpected direction towards a negative correlation between public stigma and current engagement in mental health treatment ($r_{\text{point-biserial}} = -.103$, $p > .05$). While this suggests that individuals with high levels of public stigma were also more likely to currently be engaged in mental health treatment, this relationship was not statistically significant.

Pearson correlations also identified a positive relationship between internalized stigma and depressive symptoms ($r = .132$, $p < .05$). PHQ9 score is utilized in this study as a proxy for level of depression. This suggests that individuals with more severe depressive symptoms

(higher scores on the PHQ9) were also more likely to endorse high levels of internalized stigma. There was also a significant positive relationship between depressive symptoms and intention to seek mental health treatment ($r = .19, p < .01$). This suggests that individuals with high depressive symptoms were more likely to have intention to seek mental health treatment. Level of depressive symptoms was not related to any other study variables.

Pearson's product moment correlation coefficient identified significant correlations between treatment seeking attitudes and behaviors. There was not a direct correlation between treatment seeking attitudes and current engagement in mental health treatment. However, attitudes toward mental health treatment was significantly and positively related to intention to seek mental health treatment ($r = .13, P < .05$). Subsequently, intention to seek mental health treatment was significantly and positively related to current engagement in mental health treatment ($r_{\text{point-biserial}} = .28, p < .00$). This suggests that individuals with more positive attitudes toward mental health treatment are more likely to intend on seeking mental health services in the near future. Additionally, individuals who intended on seeking mental health services are more likely to be currently engaged in mental health treatment.

Table 4. presents correlation coefficients for the main variables in the current study. For this analysis, race was coded: 1= white and 2= African American. Age was re-coded (1= young old, 2 = older, 3= old and 4= oldest old). Current treatment was re-coded (1= not currently in treatment, 2= currently in treatment). Depressive symptoms was dummy coded (1= mild depressive symptoms, 2 = moderate depressive symptoms, 3= moderately severe depressive symptoms and 4 = severe depressive symptoms. Education was coded: 1 = no high school, 2= high school graduate, 3= some college, 4= college graduate, and 5= graduate school. Gender was coded: 1= women and 2 = men.

Table 4. Correlations Among Main Study Variables for the Total Sample (N= 248)

Measure/Variable	1	2	3	4	5	6	7	8	9	10
1. Race	--									
2. Attitudes Treatment	-.175**	--								
3. Internalized Stigma	.134*	-.253**	--							
4. Public Stigma	.037	-.059	.234**	--						
5. Intention Treatment	-.050	.132*	.136*	.006	--					
6. Current Treatment	.065	-.021	.001	-.103	.281**	--				
7. Depressive Symptoms	-.013	-.005	.132*	.058	.190**	-.079	--			
8. Education	-.135*	.065	-.118	.091	.001	-.095	-.036	--		
9. Age	-.146*	-.042	-.018	-.151*	-.087	.164**	-.037	-.129	--	
10. Gender	.040	.090	.155*	.069	-.108	.016	-.016	-.100	.042	--

*p<.05, ** p<.01

4.1.4 Multivariate Analysis

According to Baron and Kenny (1986), a variable can be called a partial mediator to the extent that it accounts for at least part of the relationship between the predictor variable and the criterion. In order to test for statistical mediation, a four-step multiple regression analysis approach was utilized to examine to what extent mental illness stigma mediated the relationship between race and mental health treatment seeking attitudes and behaviors. In order to conduct a multiple regression analysis to test for mediation, certain criteria must be met. The main criteria are that the independent variable must be correlated with and precede the potential mediator variable, and the potential mediator must be correlated with and precede the dependent variable (Baron & Kenny, 1986). This approach was utilized to determine whether stigma partially mediated the relationship between race and treatment seeking attitudes and behaviors.

H.4a: Stigma partially mediates the relationship between race and attitudes toward seeking mental health treatment. A four-step multiple regression analysis approach was utilized to test this hypothesis. The first regression model was utilized to determine the direct association between the predictor variable (race) and the criterion (attitudes about mental health treatment). The second regression model examined the relationship between the predictor variable (race) and the potential mediating variables (internalized and public stigma). The third regression model examined the relationship between the potential mediating variable (internalized stigma) and the criterion (attitudes about mental health treatment). The final regression model (Table 5) determined whether the statistical significance of race on attitudes toward mental health treatment was significantly reduced when stigma (internalized and public) was controlled. Due to the significant association of education and age with race, these covariates were controlled in each regression analysis.

As shown in the path diagram (Figure 2), results of the statistical mediation tests indicated that internalized stigma partially mediated the relationship between race and attitudes toward mental health treatment. After controlling for internalized stigma, the direct effect of race on attitudes towards mental health treatment ($r = -.178, p < .01$) was reduced ($\beta = -.143, p = .034$). While this is not a total mediation model, when internalized stigma was controlled, the direct effect of race on attitudes approached non-significance. The Sobel test (Sobel, 1982) was utilized to test the significance of the indirect effect of internalized stigma on the relationship between race and attitudes toward mental health treatment. The Sobel test is a conservative test for mediation (both full and partial mediation), and is one of the most commonly reported tests for mediation analysis. As hypothesized, the Sobel test for mediation supported this partial mediation model for internalized stigma (Sobel = 2.07, $p < .05$).

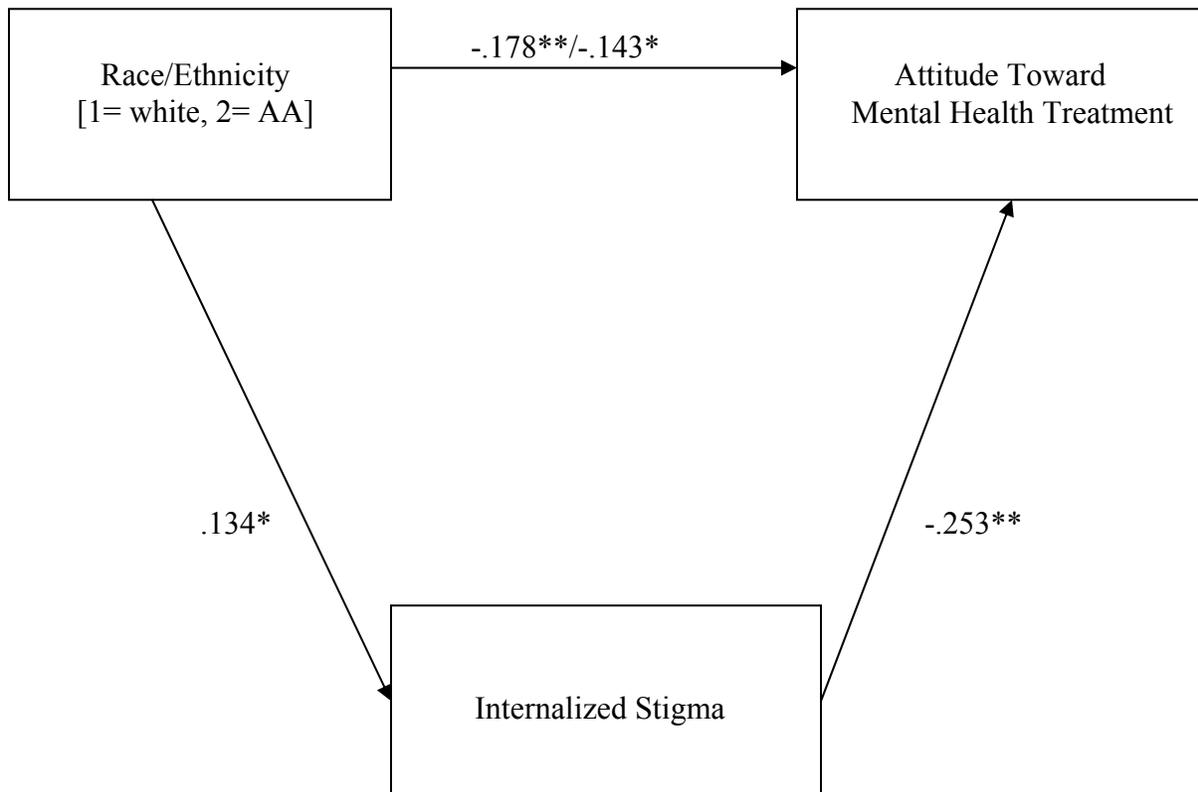
As shown in the path diagram (Figure 3), results of the statistical mediation tests indicated that public stigma did not partially mediate the relationship between race and attitudes toward mental health treatment. While there was a significant association between race and attitudes toward seeking mental health treatment, the regression analysis revealed no significant relationship between race and public stigma nor public stigma and attitudes toward seeking mental health treatment. Further, when controlling for public stigma, the relationship between race and attitudes toward mental health treatment did not change. Therefore, while internalized stigma partially mediated the relationship between race and attitudes toward mental health treatment, public stigma did not partially mediate this relationship.

Table 5. Final Regression Model for Significant Partial Mediation Model

	R	R Square	B	Beta	Significance
Model	.298	.089			
Race			-.049	-.143	.034
Internalized Stigma			-.134	-.236	.000
Education			.002	.013	.843
Age			-.019	-.054	.410

Dependent Variable: Attitudes Toward Seeking Mental Health Treatment

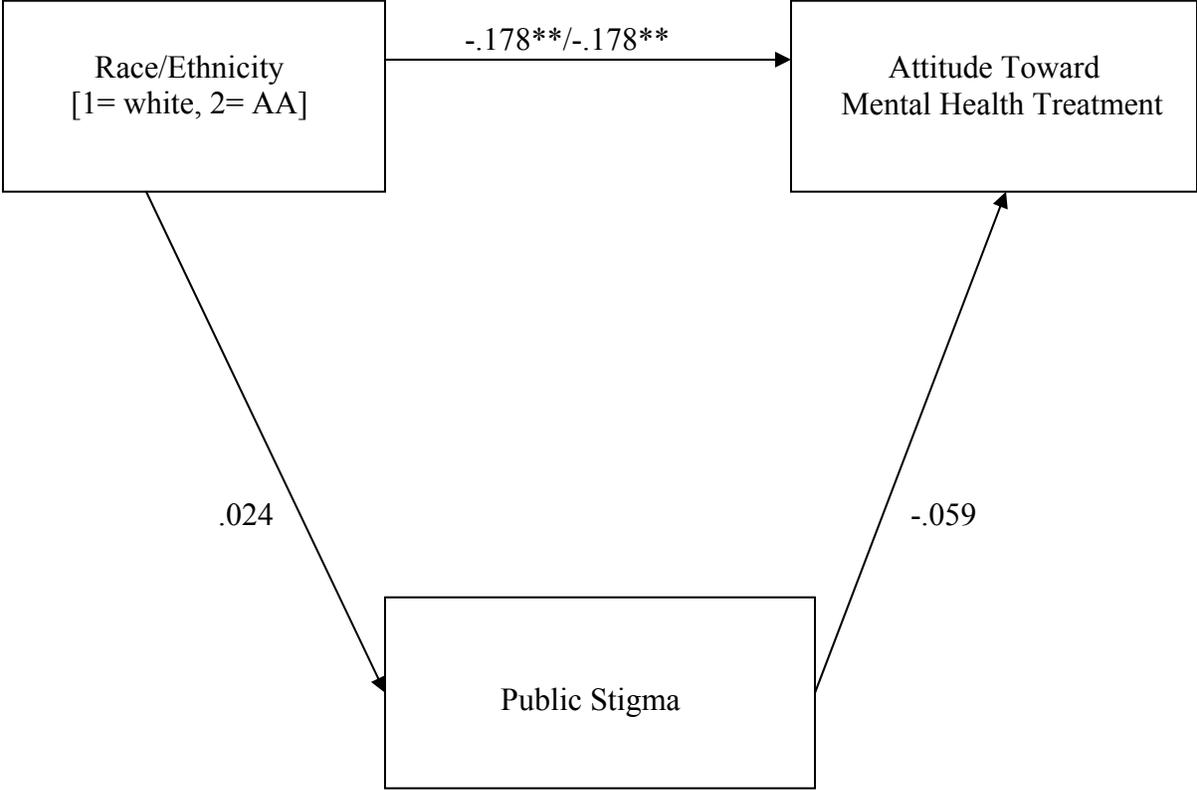
Figure 2. Path Analysis of Mediation Effect of Internalized Stigma on Race and Attitudes



* $p < .05$, ** $p < .01$

Model controls for education and age, but controls not shown to enhance readability.

Figure 3. Path Analysis of Mediation Effect of Public Stigma on Race and Attitudes



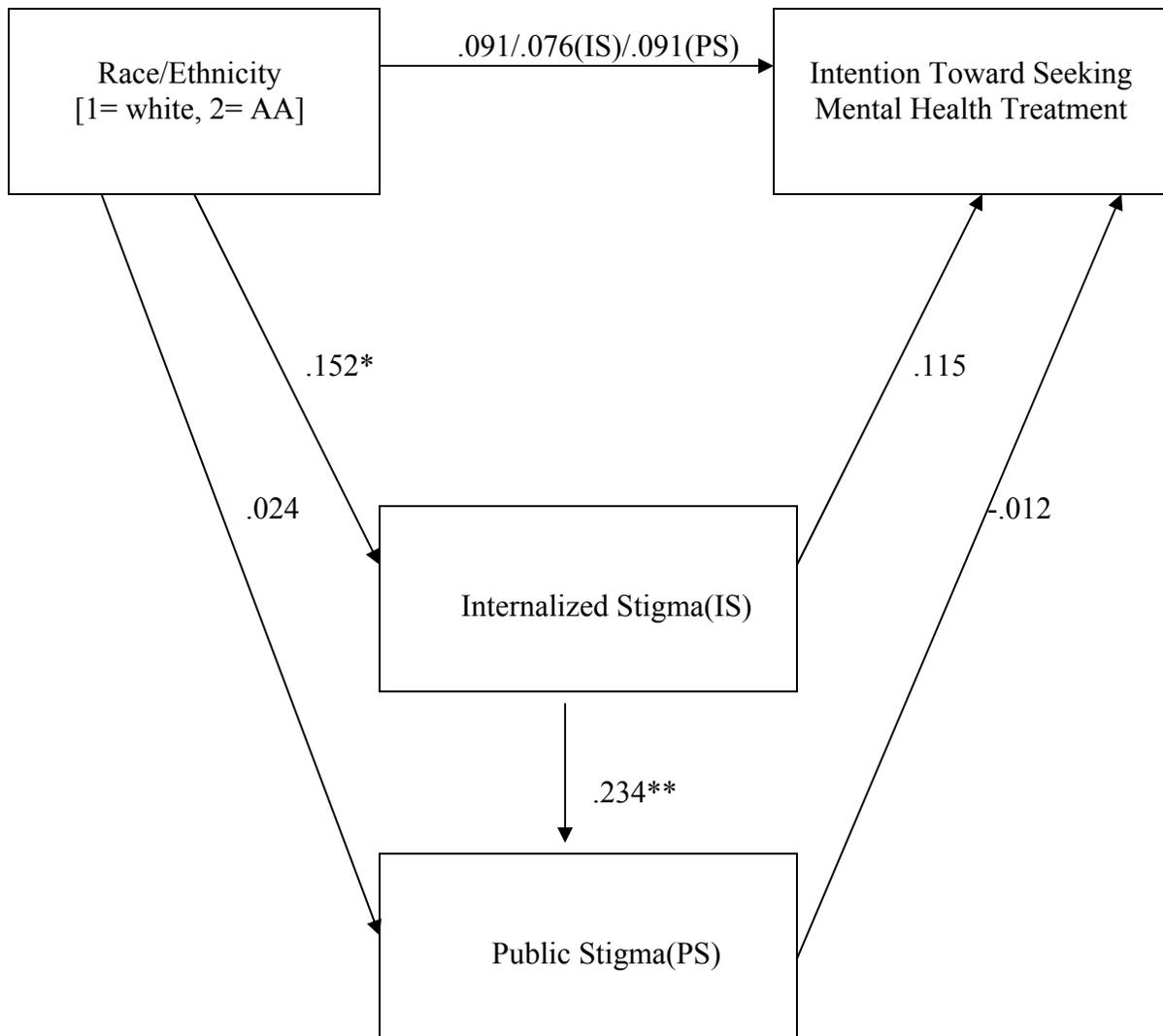
* $p < .05$, ** $p < .01$

Model controls for education and age, but controls not shown to enhance readability.

H.4b: Stigma (public and internalized) partially mediates the relationship between race and intentions toward seeking mental health treatment. A four-step multiple regression analysis approach was utilized to test this hypothesis. The first regression model was utilized to determine the direct association between the predictor variable (race) and the criterion (intentions toward seeking mental health treatment). The second regression model examined the relationship between the predictor variable (race) and the potential mediating variable (internalized and public stigma). The third regression model examined the relationship between the potential mediating variable (internalized and public stigma) and the criterion (intentions toward seeking mental health treatment). The final regression model determined whether the statistical significance of race on intentions toward seeking mental health treatment was significantly reduced when stigma was controlled. Due to the significant association of education with both race and internalized stigma, this covariate was controlled in each regression analysis.

As shown in the path diagram (Figure 4), results of the statistical mediation tests indicated that neither internalized stigma nor public stigma partially mediate the relationship between race and intentions toward seeking mental health treatment. Both models violated the primary assumption of mediation tests, which is a significant association between the independent and dependent variables. Regression analysis revealed no significant relationship between race and intentions toward seeking mental health treatment. Further, when controlling for both public and internalized stigma, the relationship between race and intentions toward mental health treatment did not change. Therefore, the relationship between race and intentions toward seeking mental health treatment, was not partially mediated by stigma in this study.

Figure 4. Path Analysis of Mediation Effect of Stigma on Race and Intentions



* $p < .05$, ** $p < .01$

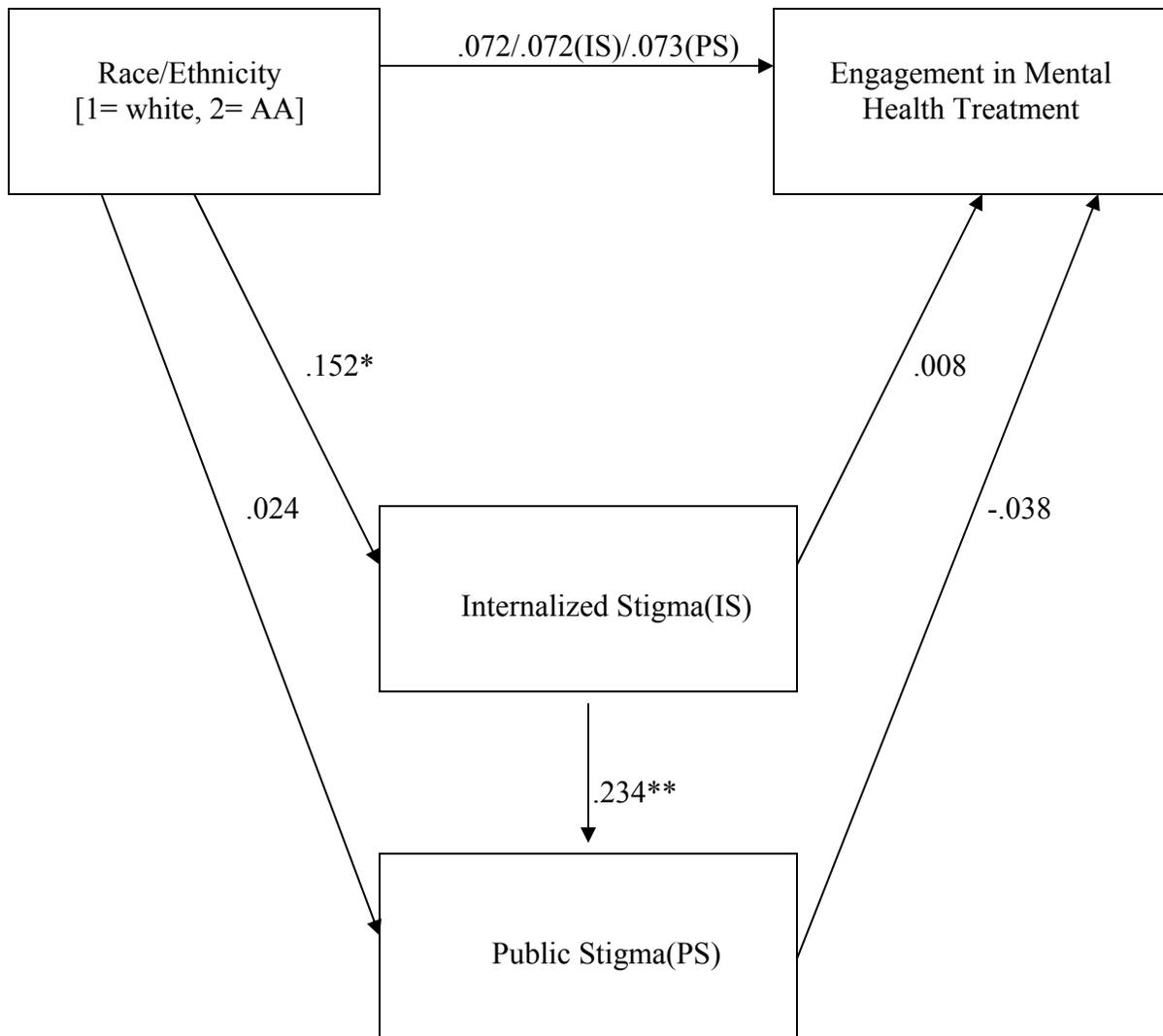
Model controls for education and age, but controls not shown to enhance readability.

(IS) when controlling for internalized stigma, (PS) when controlling for public stigma

H.4c: Stigma (public and internalized) partially mediates the relationship between race and engagement in mental health treatment. A four-step multiple regression analysis approach was utilized to test this hypothesis. The first regression model was utilized to determine the direct association between the predictor variable (race) and the criterion (engagement in mental health treatment). The second regression model examined the relationship between the predictor variable (race) and the potential mediating variable (internalized and public stigma). The third regression model examined the relationship between the potential mediating variable (internalized and public stigma) and the criterion (engagement in mental health treatment). The final regression model determined whether the statistical significance of race on engagement in mental health treatment was significantly reduced when stigma was controlled. Due to the significant association of education with both race and internalized stigma, this covariate was controlled in each regression analysis.

As shown in the path diagram (Figure 5), results of the statistical mediation tests indicated that neither internalized stigma nor public stigma partially mediate the relationship between race and engagement in mental health treatment. Both models violated the primary assumption of mediation tests, which is a significant association between the independent and dependent variables. Regression analysis revealed no significant relationship between race and engagement in mental health treatment. Further, when controlling for both public and internalized stigma, the relationship between race and engagement in mental health treatment did not change. Therefore, the relationship between race and mental health treatment seeking behaviors, was not partially mediated by stigma in this study.

Figure 5. Path Analysis of Mediation Effect of Stigma on Race and Engagement



* $p < .05$, ** $p < .01$

Model controls for education and age, but controls not shown to enhance readability.
(IS) when controlling for internalized stigma, (PS) when controlling for public stigma

4.1.5 Secondary Additional Analyses

This study was intended to look at differences by race on treatment seeking attitudes and behaviors. This author conducted formal moderation tests by race and did not find any statistically significant interactions. However, there were some interesting racial differences in the responses on the Attitudes Toward Mental Health Treatment scale (ATMHT). While white participants (80.5 %) felt that they would feel comfortable seeing a mental health professional that was from a different racial background, only 56.6% of African American participants stated that they would feel comfortable. And while white participants (59.4%) stated they would feel comfortable seeing a mental health professional who was younger than they, only 31.7% of African Americans participants stated that they would feel comfortable with a mental health professional younger than they. African Americans (67%) felt that mental health treatment would not be effective for them. African Americans (78%) felt that mental health clinicians didn't really care about you, and they were only there for a paycheck, and 67% felt that they hold negative attitudes and beliefs about individuals with mental illness. African Americans (53%) felt that mental health treatment was not a feasible option for them.

Interestingly, the African American and white participants in this sample shared some similar beliefs relative to attitudes about mental health treatment that were quite unexpected. The majority of both African American participants (67.2%) and white participants (65.7%) in this sample stated that they did not fully trust mental health professionals. Additionally, both African American participants (76.3%) and white participants (81.2%) felt that in order for mental health treatment to be effective, your mental health practitioner must be of the same racial background. Despite this sentiment, most African American and white participants stated that they would be willing to see a mental health practitioner from a different racial background than their own.

4.1.6 Summary of Quantitative Results

The results of this quantitative analysis suggest that, as predicted, African American older adults have more negative attitudes about mental health treatment and experience more internalized stigma than their white counterparts. Interestingly, older males exhibited higher internalized stigma than their female counterparts. Additionally, internalized stigma was related to more negative attitudes about mental health treatment, and in fact partially mediated the relationship between race and attitudes about mental health treatment. Further, positive attitude about mental health treatment was related to higher intention to seek treatment. And high intention to seek mental health treatment was related to higher engagement in treatment. Despite racial differences in internalized stigma and attitudes, the mean differences between African American and white older adults were not strikingly different, suggesting that older adults in general experience a great deal of public stigma and are likely to internalize stigma, and have moderately negative attitudes about seeking mental health treatment.

Older African Americans also seem to have more clinical preferences than their white counterparts, preferring an older therapist and feeling that only an African American therapist will be effective in treating them. Contrary to prediction, there were no significant racial differences on intention to seek treatment, engagement in treatment or in public stigma. The main limitation of these quantitative results is the study's cross-sectional nature, which limits our ability to interpret causality in the mediation analyses. To gain a more in depth understanding of experiences with stigma among older African Americans, we turn now to the qualitative results.

4.2 QUALITATIVE RESULTS

A total of 20 African American older adults participated in the second phase of this dissertation study. Interview participants were mostly female (85%), and widowed (70%). The majority had either graduated from high school (45%) or had completed some college (25%). Their ages ranged from 67 to 94 with a mean age of 77. To meet inclusion criteria for the first phase of the study, all participants endorsed mild to moderate levels of depressive symptoms with at least a score of 5 per the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001). The PHQ-9 scores of the African American older adults who participated in second phase interviews ranged from 2 to 22 with a mean score of 10, indicating that while there was a range of low to very high levels of clinical symptoms experienced by this sample, the majority were experiencing moderate depressive symptoms at the time of the interviews (See Table 6). This also suggests that the level of depression symptoms for at least two participants lessened between the time they participated in the telephone survey and the qualitative interviews. However, since they had recently endorsed at least mild to moderate depressive symptoms, these two older adults were allowed to participate in the interview phase of this study. Despite the generally high levels of depressive symptoms, none of the African American interview participants were currently engaged in mental health treatment, and only four stated that they had ever received mental health treatment.

Table 6. Sample Demographics for Qualitative Interviews

Characteristics (N=20)	N (%)
Gender:	
Female	17(85%)
Male	3 (15%)
Age:	
60-70	5 (25%)
71-80	9 (45%)
81+	6 (30%)
Education:	
Grade School	5 (25%)
High School	9 (45%)
College	5 (25%)
Graduate School	1 (5%)
Marital Status:	
Widowed	14 (70%)
Married	2 (10%)
Divorced/Single	4 (20%)
Patient Health Questionnaire Score:	
2-9 (mild)	8 (40%)
10-14 (moderate)	6 (30%)
15-19 (moderately severe)	3 (15%)
20-27 (Severe)	3 (15%)

In preparation for the interviews, the researcher utilized a random numbers chart (Rubin and Babbie, 2005) to select 40 African American older adults to be contacted out of the original 84 who indicated interest in participating in the qualitative interviews. They were either contacted by the lead researcher, or by a licensed master's level social worker trained by lead the researcher. This licensed social worker contacted half of the older African Americans and conducted 10 of the 20 interviews, after first shadowing the lead researcher on two interviews. When the interview participants were contacted, they were reminded of the original telephone survey they had completed, and of their statement of willingness to be contacted for an additional in person interview. Out of the 40 selected, eight telephone numbers had been disconnected, six people chose not to participate in this phase of the study and the other six were not reached. The 20 who chose to participate in the interviews scheduled a time for their interview with either the lead researcher or the licensed social worker. All the interviews took place in participants' homes, and lasted between 30 minutes and 90 minutes. Participants received thirty dollars for their time.

The interviews were digitally audio-taped and subsequently transcribed verbatim. The Qualitative Data Analysis Program (QDAP) at the University of Pittsburgh Center for Social and Urban Research (UCSUR) transcribed the 20 interviews. The qualitative interviews contained questions about respondents' experiences with and perceptions of stigma, and its impact on their treatment seeking attitudes and behaviors (see Appendix C). At 20 interviews, there was saturation of data in that the interviews no longer yielded new information. Therefore, the researcher concluded with a total of 20 interviews.

4.2.1 Thematic Analysis

The primary analytic approach utilized was theme-based content analysis of the interview transcriptions using the ATLAS.ti qualitative data analysis program. To conduct thematic analysis, audiotapes of the interviews were transcribed verbatim. These transcripts were subsequently entered in the ATLAS.ti qualitative data analysis program (See Appendix E for description). Second, these transcripts were in vivo (line-by-line) coded in the ATLAS.ti program. Respondents' own language and meanings were utilized as often as possible to represent their statements (Strauss & Corbin, 1990). A codebook was created for the continuity of codes (See Appendix D for the code book). Third, using ATLAS.ti, individual codes of data were entered into this computer program to facilitate qualitative thematic analysis. Lastly, patterns of codes were combined to form categories of data, which were then expanded into sub-themes and finally into broad themes (See Table 7).

Thematic analysis of the 20 interviews with African American older adults yielded four broad yet inter-connected themes: 1) Depression Among Older African Americans; 2) Barriers to Seeking Treatment; 3) Cultural Coping Strategies; and 4) Outcomes for African American Older Adults with Depression. An additional yet somewhat unrelated theme was identified in study results: 5) Help for Everyone Else. These themes are discussed in detail in the following sections. To aid in understanding these results a diagram of study themes and the way in which they impact African American older adults with depression is presented (See Figure 6). In addition to the summary, description, and interpretation of these themes, statements made by interview participants that reflect the themes are reported. To protect anonymity, pseudonyms are utilized in the study to represent study participants (See Table 8).

Table 7. Identified Themes and Sub-Themes

Theme	Sub-Themes	Definition
1) Depression Among Older African Americans		Participant experiences of dealing with depression in the African American (AA) community, and the way in which being an AA impacts their experiences of being depressed and stigmatized.
	1.1) Cultural Beliefs	Participant belief that in the AA culture if something is wrong with your mental health you keep it inside, you don't take it outside of your own home.
	1.2) Fear	Participant fear of mental illness and of the outcomes of seeking mental health treatment.
	1.3) Multiple Stigma	Participant perception that there is greater stigma associated with being an AA and having depression.
	1.4) Lack of Information	Participant belief that there is a lack of education among AAs and a lack of information in the AA community about mental health and effective mental health treatments.

2) Barriers to Seeking Treatment		Due to experiences of being an AA with depression and living in the black community, certain factors have become obstacles to seeking mental health treatment for participants.
	2.1) Experiences of Stigma	Participant experiences or perception of stereotypes, prejudice and discrimination based upon mental health status.
	2.2) Lack of Faith in Treatment	Participant lack of confidence in mental health providers and in the effectiveness of mental health treatment.
	2.3) Lack of Access to Treatment	Participant difficulty accessing mental health treatment due to transportation issues, lack of insurance, financial difficulties, etc.
	2.4) Mistrust	Participant lack of trust in the mental health care system; this mistrust is heightened when a service provider is from a different racial/ethnic group.
	2.5) Ageism	Participant experiences of prejudice and stereotyping based upon old age; often the participant is the one that holds ageist beliefs.

<p>3) Cultural Coping Strategies</p>		<p>Due to experiences of being an AA with depression and living in the black community, as well as encounters with factors that become barriers to seeking mental health treatment, participants identify and utilize cultural coping strategies to deal with their depression that are generally accepted in the black community.</p>
	<p>3.1) Handle on Your Own</p>	<p>Participant belief that he or she is resilient and strong and therefore should be able to handle being depressed without seeking professional mental health treatment.</p>
	<p>3.2) Push Through It</p>	<p>Participant belief that he or she should try to just push through the depression, and that eventually it will get better in its own.</p>
	<p>3.3) Let Go and Let God</p>	<p>Participant belief that prayer and a relationship with God is the first line of defense in the treatment of depressive symptoms. Although they have lost faith in mental health treatment, participants maintain faith in God.</p>

<p>4) Outcomes for African American Older Adults with Depression</p>		<p>Due to experiences of being an AA with depression and living in the black community, encountering barriers to mental health treatment, and the endorsement of cultural coping strategies to deal with depression that may be generally accepted in the black community but often are ineffective at reducing mental health symptoms, there are a number of negative outcomes for depressed African American older adults.</p>
	<p>4.1) Frontin’</p>	<p>Participant decisions to hide his or her depressive symptoms and mental health status from family and friends.</p>
	<p>4.2) Denial</p>	<p>Participant experiences of denying to others and even to oneself that he or she is depressed.</p>
	<p>4.3) Lack of Recognition</p>	<p>Participant experiences of difficulty recognizing that he or she is depressed and may be in need of treatment.</p>
	<p>4.4) Language</p>	<p>Participant use of less stigmatizing terminology to express emotional well-being to oneself as well as to others.</p>

Figure 6. Diagram of Qualitative Results

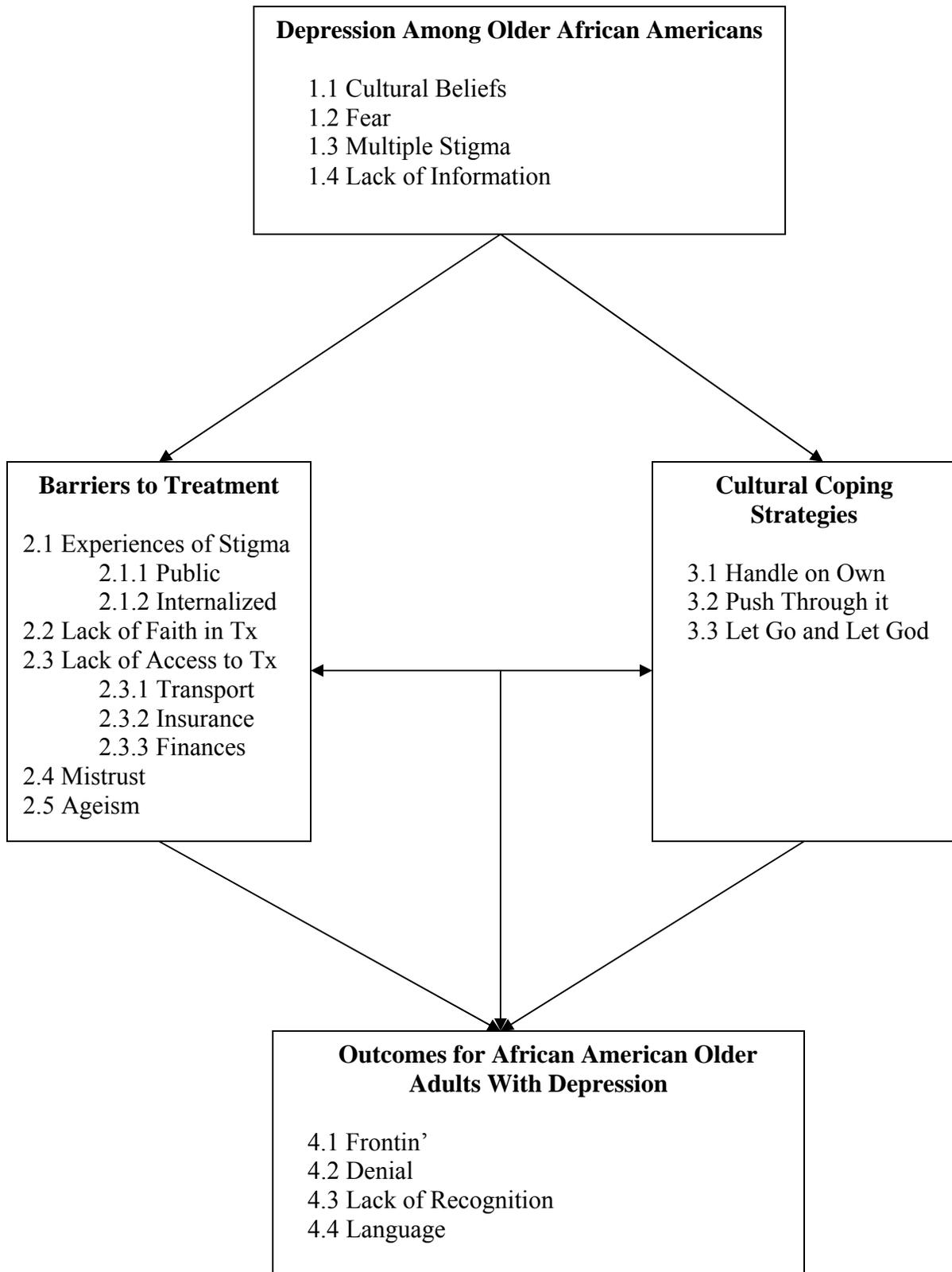


Table 8. Study Participant Pseudonyms

Pseudonym	Gender	Age	PhQ-9 Score
1.Hanna	Female	76	5
2. Marta	Female	80	12
3. Andrea	Female	73	20
4. Margaret	Female	85	22
5. Georgia	Female	68	10
6. Gerry	Male	82	7
7. Brian	Male	70	11
8. Lilly	Female	73	15
9. Mary	Female	94	15
10. Theresa	Female	79	12
11. Melissa	Female	90	6
12. Erin	Female	67	11
13. Walter	Male	75	12
14. Bryanna	Female	72	5
15. Samantha	Female	80	2
16. Elise	Female	82	17
17. Alison	Female	72	8
18. Darleen	Female	70	2
19. Joanna	Female	67	5
20. Rachel	Female	85	8

Depression Among Older African Americans

Experiences of being an African American older adult with depression in the black community and the way in which being African American impacts ones' experiences with depression and stigma is the overarching framework and most powerful theme that emerged from the qualitative interviews. The African American older adults in the current study discussed very powerful occurrences growing up an African American and in the black community, and how those experiences shaped a large part of their identity, including their attitudes and beliefs about mental health. Participants expressed that being depressed was not largely tolerated in the black community, and there was an identified fear of mental illness and of seeking mental health treatment. Participants also acknowledged that there were more stigmatizing beliefs about depression and mental illness in the black community than in other communities. Participants felt that this greater stigma and fear of mental illness was largely a result of the lack of education among African Americans about mental health and a lack of accurate information disseminated to the black community about mental health and effective mental health treatments.

Questions asked during the qualitative interview to gain information about African American older adults' experience with depression in the black community included: 1) Do you believe your race affects your experiences with the stigma of depression; 2) Has living through the Civil Rights Movement and experiencing racial prejudice affected your attitudes about seeking mental health treatment; 3) Do you think it is harder to be an African American and have depression; 4) Do you think society stereotypes you more or treats you more harshly because you are a racial minority with depression; 5) Is depression more or less accepted in the African American community as compared to the white community; and 6) Is mental illness in general more accepted in the African American community as compared to the white community.

Cultural Beliefs

Most participants believed that the black community is not tolerant of individuals suffering from depression, or any other mental health problem. Participants stated this lack of tolerance in the black community is due in part to the socialization received in the black community about mental health concerns and how to handle them in a culturally appropriate manner. Participants endorsed the belief that African Americans shouldn't talk about their mental health problems. They believed that an individual experiencing depressive symptoms or in an emotional crisis, should keep this information to oneself. One participant stated:

“I don't think we discuss it that much, black people. If you're depressed, nobody knows. You don't tell people, you know. They just look at you, figuring you might have a problem, but you don't talk about it, you don't discuss it. And nobody don't tell me, so I don't know” (Margaret, an 85 year-old African American woman).

Participants felt that the tendency of African Americans to keep their mental health concerns within in the family is part of the African American culture and the way that most black folks were raised. When asked why she didn't talk to anyone about her depression, one participant stated:

“That's the way most of us black people were raised you know. What goes on in your house, you keep it to yourself and your family, keep your secrets your family secrets and all that stuff. Uh huh and I think it's just really hard to you know, open up to anybody, whites or blacks you just keep your secrets you know” (Mary, a 94 year-old African American woman).

Participants expressed that keeping mental health concerns in the house creates a sense of fear in the black community about the repercussions of having a mental illness and help seeking.

Fear

Participants suggested that African Americans get treated worse when they have mental health problems, and therefore are often afraid of the consequences that accompany admitting you have a mental illness. One participant stated:

“Oh yeah, it’s harder because their [white] community have all these people already in it, most communities. But black communities don’t have the doctors and all these people right there, part of their families. They don’t have these people that you can go and say, “Somebody’s having a little bit of trouble.” And a lot of them are afraid that it will be on their record, like for life, and they would destroy their...it would come up somewhere and it would hurt them, and it would hurt your chances of getting a job or something. They wanted like to get over it but not let too many people know, not have it written down anywhere or that somebody could find out and use it against you later. So I think that’s most of the things where black people, being ill, they don’t want too many people to know about it. They want to keep it close to the family as they can, and like I said, pray that I get better” (Lilly, a 73 year-old African American woman).

This fear of getting treatment for a mental health problem could lead to very negative outcomes for individuals who needed mental health treatment and did not receive it. Lilly went on to talk about what happened when individuals who needed help didn’t receive help for a mental health problem:

“And that’s where we make our mistakes, because we’ve lost some...my friends have lost some nice young men, and they were afraid that their record would be messed up and they couldn’t get into schools and stuff, and they were trying to fix it without too many people knowing. I’ve seen nice, wonderful young men that killed themselves. And they were gifted and everything, and people watched them and knew that they were destroying themselves, but nobody said, ‘Go get you some medicine’.”

Multiple Stigmas

Participants believed in the impact of multiple stigmas, in that an individual experienced greater stigma when he or she has more than one stigmatizing condition in society. Participants recognized that as African Americans, they experience the stigma of being a racial minority as well as the stigma of being depressed. Interestingly, they felt that being depressed in the black community is more stigmatizing than being depressed in other communities. Participants believed that African Americans are more likely to stereotype and discriminate against other African Americans who are depressed or are suffering from another mental illness. When asked if depression was more or less accepted in the black community, Rachel, an 85 year-old African American woman, stated: "I think they [black community] would be less accepting." When asked why, Rachel replied: "Well, for one thing they would be afraid of them." Gerry, an 82 year-old African American male, stated that when you tell another African American that you are depressed: "Your machine says, you just going down the crazy maker, you know, but you're proud you know, but you're proud, 'That n-----s crazy.' The N-word." One participant expressed a similar sentiment when asked if the black community was more or less accepting than the majority white community of individuals with depression:

"Depression is less accepted in the black community. Hmm, because people just don't have the patience...you know. They say, "You crazy," and forget ya" (Darleen, a 70 year-old African American woman).

Some participants felt that due to the history of African Americans in this country, they should be resilient and able to handle depression better than other racial groups. For example:

"I...well...basically, I think...the fact that...the fact of...racial discrimination, and that we have always had so much discrimination, they made us tougher, so we can

endure hardships more, it's made us stronger, and I don't think it's harder. And it made us more resilient, like if we have depression, we can bounce back easier than white people" (Elise, an 82 year-old African American woman).

Other participants had misinformation about depression in African Americans as compared to other racial groups. One participant talked in depth about the resiliency of African American people and how they get depressed less often than other racial groups due to their history in the United States:

"The black people, they have, they have gone through so much, and they have survived and, and they know how to survive, and white people most of 'em, they seem like that they don't know how, you know, how to survive, and they get more depressed than black people do. That's the way I look at it. I mean, that's, that's the way I look at it because most black people, they haven't ever had anything, so they can get by with the little, the little things, but white people, they have had a lot, and if they lose some of what they have, well, they just go down, they get depressed. Some of 'em commit suicide and all that kind of stuff, but black people are different, it's like I tell 'em, 'All I need is a bag of beans and some water and something to cook it on, and I can survive with nothing'. But a lot of people, they, they couldn't do that, cause they wouldn't want to, and they don't want that because they used to more, but I mean I can get along with little bit of nothing" (Rachel, a 85 year-old African American woman).

This tendency for African Americans to believe that they don't get depressed could lead to an inability to recognize depressive symptoms. For example:

"Oh, they're sad; they don't know they're mentally ill, they have no idea. They have no idea how sick they are, they just don't know. I use the word mentally ill, I mean it's like, 'Y'all got cancer.' Or you know, 'I got something wrong with me,' but it's a sickness, and it can be cured, that's the part before you get too far down the line" (Andrea, a 73 year-old African American woman).

Other participants believed that the black community does not recognize the importance of mental health. For example:

“I don’t think they [black community] know how important mental health is. I mean, all their regular body, like a cold or something, they go get medicine and stuff, but I don’t think they think they should have medicine for mental problems. And most Jewish people do, because a lot of them are psychiatrists already and they grew up with it. But they don’t mind taking medication and getting and keeping their mind right. I think that’s the only group takes mental illness more serious than anyone else, they don’t feel bad about it. I mean, they’re little kids when they go to the psychiatrist. That’s one group, I think, that’s on to mental illness. They get help all the time, they use psychiatrists and stuff like that all the time. The other people don’t” (Lilly, a 73 year-old African American woman).

Lack of Information

Participants often stated that the reason African Americans don’t recognize the importance of mental health is that the African American community is less informed about depression, mental health, and mental health treatments than other communities. Participants felt that this lack of information leads to negative attitudes about seeking mental health treatment and reduced help seeking behaviors, simply because they were not made aware of the opportunities available to them. For example, when asked whether she would be willing to take an anti-depressant pill to reduce her depressive symptoms, one participant questioned:

“Is there a pill? I’ve never heard of it. I wish I had known, because I don’t take nothing from [my doctor] and I don’t take anything. I never knew. Sure, right. Sometimes you have a headache and you take a Tylenol, after all you feel better. So that one will make you feel better” (Hanna, a 76 year-old African American woman).

Other participants agreed that the lack of information and education negatively impacted African Americans' decisions not to seek mental health treatment. Participants felt that while oftentimes African Americans simply don't want treatment, if an individual did want to seek mental health treatment, people in the black community are not informed of opportunities available to them. When asked why she thought African Americans sought mental health treatment at much lower rates than white Americans, one participant stated the following:

“Because black people don't want treatment. I think because they not educated about it, you know how important it is. But ah, I don't think our black people, they just, they just don't care it seem like. They can get a lot of help, but they just don't seem to want to. I don't know. I don't think they're informed. People don't tell them. Just like this program, I'm for as long as I've been in Pittsburgh, I never heard about this program” (Mary, a 94 year-old African American woman).

In addition to the need for the black community to receive more information about mental health and available treatments to increase the number of people who seek mental health treatment, participants also felt that increased education would help to eliminate some of the stigma in the black community towards individuals who are suffering from depression and other mental illnesses. For example:

“I think we need to be more education to, in order to help 'em, you know. I think people should, and we should be more compassionate of people's feelings, you know. Then maybe we would treat 'em a little better than we do. Cause I know, even with my cousin, you know, I think we coulda did more for her, to help her, you know than we did, we didn't, we should've, you know, for families and communities too” (Joanna, a 67 year-old African American woman).

Barriers to Seeking Treatment

Participants' experiences dealing with depression as an African American and living in the black community seemed to have an impact on their treatment seeking. There were a number of cultural beliefs identified that socialized African Americans to keep their mental health concerns to themselves. And a lack of education and information about mental health in the black community led to stigma and fear. Not surprisingly, these experiences and beliefs created factors that inevitably became barriers to treatment for African American older adults with depression. Out of the 20 African Americans interviewed, all 20 had experienced moderate to severe depressive symptoms at some point during their lifetime, yet none were currently in mental health treatment for depression and only four reported they had ever been in mental health treatment. The lack of engagement of African American older adults in mental health treatment was partially due to the powerful obstacles that deter them from help-seeking, despite perceived need and despite experiencing significant depressive symptoms.

Participants identified a number of barriers to help seeking that seemed to stem from their experiences of being older African Americans dealing with depression. Some of the most prevalent barriers acknowledged were lack of faith in mental health treatment, lack of access to treatment, mistrust, ageism, and stigma. Questions asked during the qualitative interview to gain insight into barriers to seeking treatment included: 1) Have you had negative experiences in your community due to your feeling depressed; 2) Have you had negative experiences in treatment or in your attempting to seek mental health treatment that you believe are due to your depression, your race, or your age; 3) What were barriers to getting help for your depression; 4) Has stigma affected your decisions about whether or not to seek treatment; and 5) Has stigma affected what kind of treatment provider you want to see.

Experiences Of Stigma

In this study sample, experiences of stigma were prevalent among African American older adults with depression. Additionally, stigma was identified by a number of participants as a barrier to seeking mental health treatment. Out of the 20 participants interviewed, 19 believed that people negatively stereotype individuals with depression and 17 believed that people with depression are stigmatized in society. Participants identified a number of negative stereotypes about individuals with depression. When asked what stereotypes exist about people who are experiencing depression, one participant stated the following:

“They’re dangerous. They can get violent... They pass on their genes to other...to their children, you know. That, they’re completely...they’re crazy. That they’re crazy, yes, that’s what you call crazy. When a person’s depressed, they’re crazy. I think that’s a stereotype, because people that are depressed are not necessarily crazy” (Elise, a 67-year-old African American woman).

Alison, a 72 year-old African American woman, discussed similar stereotypes about people with depression. She stated that people with depression are often described as being: “Crazy, listless, lifeless, opinionated.” Darleen, a 70 year-old African American woman stated that people with depression are often seen as: “Crazy and undependable.” One participant stated that he experienced being stereotyped when he was going through a depression:

“Think they ain’t trustworthy, or something, you know. This whole thing like, ‘You crazy or something.’ You ain’t crazy, but they think you’re crazy, because you might act different or something. I think that a lot of people still got things about mental illness. They think you’re going to harm them or something like that or...Dangerous or something like that” (Walter, a 75 year-old African American man).

The experience of being an African American older adult with depression impacted experiences with stigma. Participants believed that stereotypes about depression were more severe if you were also a person of color. For example:

“People are against you, nothings’ going your way, yeah, just feel sorry for yourself. Well, especially if they’re colored. And for right away they say, ‘Oh, you know, they down on ‘em cause they black.’ And they’re you know, it depends on the color. It differs yeah for white from black. [If you’re black and depressed] you’re worthless, you know” (Joanna, a 67 year-old African American).

In addition to identifying stereotypes about individuals suffering from depression, participants also discussed experiences with public stigma. Public stigma refers to real or perceived attitudes held by the general public about individuals with a mental illness as well as the experiences of prejudice, being stereotyped or discriminated against due to an individuals’ mental health status. Participants talked about situations where they witnessed the stigmatization of individuals in their community who were dealing with depression. In these situations, individuals with depression were not only stereotyped, they were additionally treated negatively simply due to their mental health status. This was important because witnessing the stigmatization of others amplified the belief that they could and would be stigmatized. One participant discussed a situation in which she stigmatized a depressed family member:

“I have a sister-in-law who just got out of Mayview, and right away we said, ‘Oh we knew it was coming.’ You don’t, we didn’t lift her up, we talked about her, and that’s what most generally, they think, ‘Oh, there go the crazy one,’ and you know that. And, that’s the way we think, you know, we don’t think good about a person. Nobody want them around, you know” (Joanna, a 67 year-old African American woman).

Erin, a 67 year-old African American woman, stated that she knows people who stigmatize individuals suffering from depression. She stated that when a person with depression comes around, people in her community: “look at them strange, or make little comments that shouldn’t be...I don’t do it, but I’ve seen people do it...heard people. Oh, she’s retarded, or she’s crazy, something like that.” One participant talked about an experience of stigmatization towards a depressed man in her community:

“Everybody say he’s kookoo. He’s crazy, but I don’t feel like he’s crazy. I think he’s just got these inner feelings in there. He goes all way around and comes back and they say he’s the neighborhood crazy, but I never seen him do anything. Yeah ‘cause I have some neighbors say he’s crazy. Because he’s not smiling. They said like he’s crazy, he’s crazy. ” (Mary, a 94 year-old woman).

In addition to witnessing the stigmatization of others, many participants talked about their own experiences of being stigmatized due to being depressed. One participant talked about her experiences with her family and friends when she was going through a depression. When asked how people treated her differently due to her depression, she stated the following:

“They uh...got away from me. Yeah, it depressed me for years. It was terrible, I didn’t stand on my...I didn’t stand guard, I didn’t say anything, but the words they were saying about me...weren’t true. Yeah, like when you...you know, you haven’t seen in a long time and they just look at you and put their head up in the air, and you know they know you. And you speak to them; they just throw their hand up and don’t look at you. ” (Hanna, a 76 year-old African American woman).

Darleen, a 70 year-old African American woman, stated that when she was depressed the people around her treated her differently. When asked what she thought her family’s reaction

was going to be when she told them she was depressed, she stated: “They wouldn’t trust [me] to do things, you know. They would look at [me] funny and talk about [me] and things like that”. One participant had a very angry reaction to stigmatization. She stated that people treated her like she was stupid when she was depressed:

“Talk to me like I got good sense because I do have good sense, and don’t talk down to me, because I’m not stupid. And do treat me like you treat everybody else. Just because I’m depressed don’t mean I’m stupid. Oh, ‘cause they just go into the depression...They think you’re crazy, don’t have time to give you a decent conversation and find out the basics for what’s going on” (Alison, a 72 year-old African American woman).

Participants connected their experiences of public stigma with their decisions to keep their mental health status to themselves. Many participants talked about their decisions not to tell the people around them that they were feeling depressed. In fact, many people lied about their emotional state to hide their mental health status from family and friends (discussed further in the “frontin” section). Participants were worried about the reactions they would get from people if they found out about their depression. When asked if she talked to her family about her depression, Marta, an 80 year-old African American woman stated, “I didn’t talk to them because I worried about, ‘Is she going crazy?’” Other participants stated that people just don’t understand mental health, and therefore you risk being treated differently if you tell people how you are feeling:

“What’s your problem? We don’t want nobody to know, they feel like...you mention mental, ‘Oh no...that’s a wrong thing.’ Now they feel like they crazy. And a lot of people don’t understand mental health does not mean you’re crazy” (Andrea, a 73 year-old African American woman).

While many participants talked about their experiences of being stigmatized by others, some participants also talked about their experiences with internalized stigma and how they felt about themselves. Internalized stigma occurs when an individual who has a mental illness internalizes the real or perceived beliefs held by the general public about mental illness and the individual in turn apply those negative beliefs to how they feel about him or herself. Participants talked about feeling bad about being depressed, and wondered why they could not pull themselves out of it. Participants felt that many people in their community go through hard times, so if they are depressed and can't get through their sadness then they must not be very strong. Andrea, a 73 year-old woman stated that she felt that having depression made her weak: "I think I did thought it was a weakness." One participant stated that he believed having depression made him weak, and that he blamed himself for his depression:

"I think [of depression] as a weakness. Well, the person with the mental health problem and everything, people just don't seem to understand the person and everything, with that mental problem. They want to dog them and everything. Yeah, I want to just beat myself up and cuss myself out and everything like that, you know. Like, 'You dummy, shoot, why'd you do some foolish thing like that?' I just down rate myself" (Brian, a 70 year-old African American man).

In addition to identifying the public and internalized stigma of depression, participants also discussed experiencing the stigma about seeking mental health treatment. For participants, there was a difference between being stigmatized for having depression, and being stigmatized for needing to see a mental health professional for their depression. Walter, a 75 year-old African American man, stated: "Nobody mentions the word psychiatrist. You know. First thing they think about is something wrong with your mind." Other participants talked about the stigma associated with mental health treatment facilities in the Pittsburgh area:

“See, because back in the day, if something was wrong with your mind, you went to an institution. As I would say, ‘Back in my day’ when I was younger. Mayview was the place, oh, you don’t go there. Or Western Psych, you didn’t go there. St. Francis? Oh no!”(Andrea, a 73 year-old African American woman).

Participants identified a relationship between the stigma associated with mental health treatment and treatment seeking attitudes and behaviors. Some participants talked bluntly about the stigma associated with seeking mental health treatment and how it can impact mental health treatment seeking behaviors, for example:

“Why would anybody say that they’re going to see the shrink? And seem to be glad about it. I just don’t get it. If people got the blues, they keep it to themselves. I think mental depression and mental health is something that the people with whom I associate, they keep it to themselves. If they’re going to the shrink, you’re going when nobody’s looking” (Gerry, an 82 year-old African American man).

For participants, it was often the negative connotation associated with having a ‘mental illness’ that deterred individuals who needed mental health treatment from seeking care. When asked why she chose not to seek mental health treatment for her depression, one participant stated:

“Because it was never helped. We never got the help. Coming along, if you were sick, oh the hospital was the last place you went, or talking to a shrink was always a put down. I mean it never dawned on you that you might need help, and it might not, but anything you’d label on the mental, we’d run from it. ‘I’m not crazy, I’m not this and that, Oh, I’m fine.’ And that’s why a lot of us did not seek the help that we really need, because they put it...they put, ‘Oh, mental health’ on it. If they hadn’t have put mental health, I think more of them would have seeked help” (Darleen, a 70 year-old African American woman).

The label attached to mental illness and seeking mental health treatment often deterred individuals from seeking mental health treatment. This may be particularly relevant in the African American community, where participants identified the belief that individuals should be able to handle their depression on their own and that it is a weakness to seek mental health treatment from a mental health care provider. For example:

“That label, it’s that label that stops a lot of us from...oh no, you take back in my mom’s day, she had a problem...she wasn’t going to tell anybody. You didn’t tell anyone. Oh, they put it on...the crying spells...they put it on menopause. A lot of problems they blamed, oh, she’s just going through menopause, or, ‘No, that ain’t nothing wrong with you, PMS.’ ‘She’s on her period.’ I’m just saying, and it was misunderstood. A lot of help that we should have gotten was misunderstood as to where it was needed and what was needed. That I can say. Because, I know...like I said I came up in the south...and I think a lot of it, I think we would have been better if years ago, people would have gotten mental health, but people always, ‘Oh, they’re crazy.’ So they avoided mental health, and I’m saying, I know a lot of people that should have been...should have gotten help, but they didn’t, they didn’t” (Andrea, a 73 year-old African American woman).

Lack of Faith in Mental Health Treatment

Many participants expressed a lack of faith in the effectiveness of mental health treatment, the ability of mental health professionals, and the capability of the mental health service delivery system in general. Some participants felt that the mental health service delivery system is flawed, and simply does not work. Participants believed that oftentimes individuals in need of help, are unable to get that help. This caused many participants to lose faith in the ability of the healthcare system to treat individuals suffering from mental health problems. For example:

“Nowadays, like people with mental illness say this, they don’t get...they don’t seem to get help. Like they had on TV, they close mental hospitals and just put the mental ill out in the streets. They don’t help the mental health, it seems like. They say they don’t have money for them. Look like they used to, if you had mental illness they’d put you in a hospital and help you or something, but nowadays, there’s a lot of people with mental illness, they just put them on the street and they have to fend for themselves and they don’t get any help” (Darleen, a 70 year-old African American woman).

Participants also expressed a lack of confidence in mental health treatments and mental health care providers. Participants believed that treatments for mental health problems were ineffective and that mental health care providers often made mistakes. When asked why she chose not to seek mental health treatment when she was experiencing severe depressive symptoms, one participant stated:

“I don’t have confidence in medicine enough to believe that they know what it is, that they can even diagnose it right, because they made so many mistakes in other things like kids, you know, you hear on the TV they diagnosed this kid with attention deficit disorder, and it’s not even that. It’s something else. And whatever they give them seems to suppress something good that they naturally have, and they’re depressing it, they’re depressing that, whatever that positive thing is that these kids have all this energy, they’re depressing it, and they didn’t even know what it was. And they’re treating one thing and it’s another. They’re treating depression, and it’s not even depression, it’s something else. So I don’t have enough confidence that they know what they’re doing when they try to give you something for depression” (Elise, an 82 year-old African American woman).

Participants felt that mental health professionals would be not be able to effectively reduce their mental health symptoms. Mary, a 94 year-old African American woman believed that her experience with mental health treatment was not effective. She stated that seeking

mental health treatment was: “A waste of good insurance money and waste of my time.” This sentiment was similarly expressed by a great majority of study participants. When asked if she had talked to her doctor about her feelings of sadness and depression, Lilly, a 73 year-old African American woman stated: “Not about depression, I go to the doctor...I got a lot of doctors, I go to the West Penn Hospital for different things, you know? But I don’t say anything about depression”. When asked why she did not talk to her doctor about her depression, she stated “I don’t think there’s anything they could do to help me.”

Participants expressed concern about the methods mental health professionals have for treating depression. Many participants were against taking anti-depressant medications, and believed that mental health care providers would attempt to persuade them to take a pill to relieve their symptoms. Erin, a 67 year-old African American woman stated: “They [doctors] wanted to put me on medication, but I don’t think I need...I don’t think I need it.” Other participants expressed similar concerns:

“Don’t give me no medicine that’s going to make me sicker than I am...and doctors are famous for that. I want to know the side effects of everything I’m taking, if it’s not...if it don’t suit me, I will not take it. I don’t care who you are, they’re not God, they’re doctors” (Alison, a 72 year-old African American woman).

One participant felt that she had been pressured into participating in a support group for depression even after she had strongly expressed her disinterest in participating in such a group:

“I didn’t want any pity parties anything like that ‘cause that makes you more depressed, so I was able to talk to friends about how I feel and talk to my pastor and I never did go to any of those groups that they wanted me to go to ah, grief, groups. I didn’t feel like I needed that” (Mary, a 94 year-old African American woman).

Lack of Access to Mental Health Treatment

In addition to a lack of faith in mental health treatment, participants also felt that they had difficulty accessing mental health treatment. Participants identified transportation, financial burden, and a lack of health insurance as reasons for why they chose not to seek mental health treatment. When asked what barriers they experienced in seeking mental health treatment for depression, three participants identified difficulties with transportation. The participants who identified transportation as a barrier were also the oldest participants interviewed and appeared to additionally have physical health limitations. In addition to transportation, a number of participants cited finances and a lack of health insurance as significant issues keeping them from viewing professional mental health treatment as a viable option. Participants felt that they might be rejected if they attempted to seek mental health treatment and were unable to pay for it. Rachel, an 85 year-old African American woman stated: “In the black community, they don’t have the money, they can’t afford to send them, to treat, you know, to treat them, so they [mental health care providers] just don’t want them around.” One participant experienced being turned away for care because her health insurance did not cover mental health treatment:

“I think a lot of them don’t want to ask questions cause they don’t want, they don’t want to ask for help cause you don’t want to be, you know, rejected, you know. So that, I think that plays a big part in it because...For getting mental help, you know and because a lot of them don’t have the medical attention and medical insurance or something like that, and I think a lot of that is, hinders them from seeking help. They don’t have the right insurance, because I went through that, ugh. And it’s, it’s something, that you feel like, well, none of you going cause they ain’t gonna look at me cause I ain’t got, you know, you know that way. It’s kind of something, you, you feel, you feel rejected, you know” (Joanna, a 67 year-old African American woman).

Mistrust

For some participants, it was mistrust and negative previous experiences with the mental health system that led to negative attitudes toward mental health treatment and reduced treatment seeking. As discussed in the first section, African American older adults with depression tended to have a fear about mental illness and seeking mental health treatment. Therefore, if an African American elder got up the courage to actually seek mental health treatment and subsequently had a negative experience with the mental health system, this created a barrier to treatment seeking. These negative experiences often led to participants' lack of trust in mental health service providers, particularly if they had a white provider. This lack of trust also had an impact on participants' attitudes about subsequently seeking mental health treatment and ultimately became a barrier to help seeking. Marta, an 80 year-old African American woman stated, "Right, I can handle it on my own ...I don't trust nobody else." Other participants talked about the importance of being able to trust your provider, and how difficult trust can be if the race of the provider and consumer of services are different. For example:

"I'd go and look them right in the eye and talk to them. You can tell by what people are about if you look them dead in the eye when you talk to them. Especially, I'll say this, especially white people. Look them dead in the eye. 'cause they looking at you and I'm looking at them and we know, you know. You can tell if you can trust" (Georgia, a 68 year-old African American woman).

Participants often associated their negative experiences with mental health treatment to their racial status as African Americans. These negative experiences could be self-experienced, or the experiences of others in their social network that created a barrier to their mental health treatment seeking. For example:

“I just, I just, I’m just through my experiences with my cousin and that, and I think that we didn’t help any, you know. In, in the, even when she got treatment, she went in, but she seem like they weren’t doing her any, to me, they didn’t help her, you know. So I don’t if know what it was, her, but she, she was involved, she was a handful, so it might’ve been they were just tired of her, you know. To her being black, mmmhmm. I don’t think you have much support system being black period, you know”(Joanna, a 67 year-old African American woman).

Mistrust of service providers, particularly those from different racial backgrounds, appeared to be pervasive. However, some participants talked about the development of a relationship with their service providers, and identified how this relationship can break the barrier of lack of trust in service providers. One participant talked about her initial skepticism of her doctor, but by relating to him through Christianity and his ability to form a friendship with her, she began to gain confidence in his ability to help her with her mental health problems:

“I had confidence in my doctor... He was, and I found out he was a Christian, so I felt as though I could say anything to him. And since my life was in his hands I did, some, some things I could’ve kept to myself, you know, but I unloaded. I felt, yeah, yeah, we had, we had that relationship, and he had told me, call him anytime, and I go in the office, and I say, ‘Oh well, here I am doc,’ I’m telling you this, this, and this. So, you know, and he would listen” (Joanna, a 67 year-old African American woman.”

Ageism

For some participants, their age was a barrier to seeking mental health treatment. Participants believed that they were too old to be helped, and that mental health services should be reserved for younger individuals who could better benefit from them. When asked why he had not sought mental health treatment for his depression, Brian, a 70 year-old African American

male stated, “I don’t know...age, I mean...you seem like you go down in age and everything, because you’re getting older and whatnot, you know. And you know, you ain’t got much longer to live and everything like that.” Mary, a 94 year-old African American woman held similar beliefs. When asked the same question she stated: “Ah and I am, I just figure at 94 you know good and well, you ain’t gonna be here that much longer now”. She goes on to say “I wonder why they want to waste their time on older people when they could use younger people that have more to give.”

For African American older adults, ageism may be the result of their experiences with the stigma of aging, which adds another dimension to the issue of multiple stigmas. In addition to identifying the stigma associated with depression, mental health, and seeking mental health treatment, many participants also identified the stigma associated with being old. For most participants, this stigma manifested as internalized stigma and affected how participants felt about themselves. Marta, an 80 year-old African American woman talked about feeling old and stated that sometimes she thinks: “Hey, I’m 80 years old and what am I here for?” Rachel, an 85 year-old African American woman stated that aging was contributing to her depression. She stated: “Because I’m old and I can’t do the things that I used to do, and, and I just I don’t know I just wish I could, but I can’t, so I just don’t, I just sit.” Hanna, a 76 year-old African American woman talked about her experiences with aging: “You get older, you got to try harder. You do. You really do ‘cause I don’t want to be a lazy old person you know, just lay around putting on life. That’s when depression and Alzheimer’s sets in on you ‘cause you have to keep your mind active you know.”

Participants also perceived public stigma about being old. Some participants felt that older adults are treated negatively in society and are sometimes discriminated against and stigmatized simply based upon their old age. For example:

“Well, a lot of people got a lot of problems with hiring older people, or even the way they treat them, ‘You old, you can’t do this, you can’t do that,’ or something like that, but no, that’s their problem not mine” (Walter, a 75 year-old African American man).

Many participants believed that experiences of depression were different for people based upon their age. Most participants believed that depression was related to aging. Participants believed aging brings more reasons to become depressed, and therefore older individuals are more likely to go through a depression. One participant discussed feeling a decline in her social circles as she aged, which made her feel more isolated and sad:

“As you get older, because when you’re young, you don’t think...there’s nothing wrong. Now the older you get, and I think when it’s fewer, the older you get, the more you get to that place where nobody cares. And those are the stages that it sets in. The less people come past, the less you have time to think about what they didn’t do, or you have time to bank on, nobody cares. But I think the older you get, the more depression sets in, because you get to the place where nobody cares” (Andrea, a 73 year-old African American woman).

Participants believed that most people think that depression is a normal part of the aging process, which negatively impacts treatment seeking because an individual thinks what they are experiencing is normal. One participant stated:

“Well, they say, ‘Well, you’re just getting old.’ Yeah, you’re supposed to feel this way, or just because you get older you’re supposed to feel one way or something like that” (Walter, a 75 year-old African American man).

Cultural Coping Strategies

Participant experiences dealing with depression as an African American and living in the black community negatively impacted their treatment seeking. These experiences and beliefs led to factors that inevitably became barriers to seeking mental health treatment for African American older adults with depression. In the current sample, despite high levels of depressive symptoms, very few sought mental health treatment. Since these older adults were dealing with significant mental health symptoms, yet encountered a number of barriers in thinking about or attempting to access mental health treatment, they had to engage in other activities to keep themselves from getting progressively worse. They had to in fact identify coping strategies that were effective and that were culturally acceptable; strategies that other individuals in their social network would accept and not stigmatize them for. These strategies were a necessity for study participants and were a result of their experiences being an African American, living in the black community, and encountering the pervasive barriers keeping them from seeking professional mental health treatment.

Participants identified a number of strategies to cope with their depression. The most salient strategies included handling depression on their own, pushing through the depression, and relying upon God. There were no specific questions asked during the qualitative interview to gain an understanding of how older African Americans cope with depression. However, the researchers used probing questions to find out what they did on their own to manage their depression if participants stated that they had not sought mental health treatment.

Handle On Your Own

A common strategy for dealing with depression identified by study participants was to handle it on their own. Participants could recognize they were depressed and needed to do something to feel better, however seeking professional mental health treatment was not an option for them. Participants felt seeking professional mental health treatment should only be viewed as a last resort, and in the meantime one should do anything and everything in their power to get over their depression on their own. Walter, a 75 year-old African American man stated that African Americans deal with a lot of stress and depression in life and they should be able to handle their emotional state on their own. He stated: “I think that we [African Americans] just had to just deal with it, get through it on our own. I think so, I really do.” Other participants expressed similar beliefs. Lilly, a 73 year-old African American woman stated:

“Well, if I need to...I’ll go to other people, but if it’s something I can do for myself, then I try to do it, I’m not always to run to somebody, do this for me, do that for me. I try to do it myself”.

Participants’ belief that they should handle depression on their own stemmed from their experiences of being an older African American with depression and living in the black community. For example, in the black community you don’t talk about your mental health problems; you keep it to yourself. Marta stated: “I’m sitting in this state. I need to talk to me. Tell myself what to do.” Therefore, you have no one else to rely on but yourself. For example:

“Right, I can handle it on my own. Not on my own, but me and the Lord. I don’t trust nobody else. I don’t know, but I just don’t want to talk to nobody about my business” (Marta, an 80 year-old African American woman).

Participants believed they have the power to handle their depression on their own, and that if they were strong enough they could beat it. Participants expressed the belief, if you could not handle your depression on your own that you were weak, and lacked personal strength. This belief seemed to stem from their experiences as an older African American living in the black community. Participants endorsed the belief that black people are resilient and have gone through a number of stressors and hardships, and these experiences have made African Americans a strong race of people. Therefore, as an African American individual, you should be able to handle your depression on your own by using your personal strength. One participant stated:

“It was mind over matter, that’s all. Sheer will, what you want to do and what you don’t want to do. Don’t do. Keep your eye on the prize, as they say in the south” (Gerry, an 82 year-old African American man).

When asked why she chose not to seek mental health treatment for her depression, Andrea, a 73 year-old African American woman stated: “You know what? I just felt like...I’m strong enough. I felt like I was strong enough to get through this.” Other participants expressed similar sentiments, for example:

“I don’t think it was hurting anything, but like, if I was able to give away you know things to start changing my pattern of life and that helped me with my depression. That’s why I thinking all the time you don’t need to go to a psychiatrist, but some people do now ‘cause they’re not strong enough you know. I think I have a lot of strongness in me, strength. I have a lot of strength in me” (Mary, a 94 year-old African American woman).

Push Through It

In addition to participants' belief that they should be able to handle depression on their own, participants also perceived that others expected them to be able to just push through their depression. Participants felt that African Americans believe you should be able to just push through depression because in the black community depression is often not viewed as a real medical illness. If people don't view depression as a medical condition, it is likely that they will also believe that you should just be able to get over it. Andrea, a 73 year-old African American woman stated that when it comes to African Americans and depression: "You know what, we [African Americans]...us people never think we're mentally ill, let's put it that way. It was always, Oh, you're not mentally...there's nothing wrong with you." One participant expressed a similar sentiment:

"I don't know, I think, I don't know, I think if it's family you sort of, well, deal with it. Not that you accept it or not, you just deal with it, and I think that's throughout our whole being involved in being black, you just, things you just learn to deal with" (Joanna, a 67 year-old African American).

This perception of other people's expectations seemed to have an impact on participants' attitudes toward seeking mental health treatment and their decision to not seek mental health care, especially when expressed by family, friends and other members of their informal social network. Lilly, a 73 year-old African American woman, stated: "I think that they think you should handle it on your own." Erin, a 67 year-old African American woman stated: "People overlook it, people think you get better by yourself that you don't need help, you don't need

support.” When asked if her social network influenced her decision not to seek treatment, one participant stated:

“Well, yes, because most people...if you’re depressed, they’ll tell you, Get over it. You know, get over it. You could do better, or just get up and do something, get it over with. Yeah, just snap out of it, and go on with your life and change or do something to make a difference or something like that. Yes, ‘cause most people expect if you have a hard time, it shouldn’t last as long. Oh, you’ll get over it...time will pass. But sometimes you don’t. Most of the time...most people don’t understand” (Darleen, a 70 year-old African American woman).

Let Go and Let God

The most culturally accepted strategy for dealing with depression identified by participants was to turn their mental health problems over to God. The majority of participants discussed their relationship with God during the interviews, although there were no direct questions about God or spirituality asked by interviewers. When asked why they did not seek mental health treatment, a great majority responded by talking about their relationship with God and their belief that the Bible and prayer would heal them. Margaret, a 94 year-old African American woman stated: “Just let go and let God”. When asked why she had not sought mental health treatment for her depression, Marta, an 80 year-old African American woman stated: “Right, I can handle it on my own. Not on my own, but me and the Lord.” Another participant had a similar response:

“No, I didn’t want to talk to anybody. I do a lot of reading of my bible that helped me a lot and then one day I decided to talk to my pastor and ah, he told me how about the serenity prayer” (Georgia, a 68 year-old African American woman).

Participants talked about the power of prayer, and how turning your problems over to the lord will heal you. Participants often felt their first line of defense against depression and mental health problems was prayer. For example:

“Take your burden to the Lord and leave it there. “I’m telling you, you take it to the Lord, because you know how to take it and leave it, I don’t. I take it to him and I keep picking it back up. That’s why I’m telling you, you take it to the Lord. Well, you agree with me in prayer” (Elise, an 82 year-old African American woman).

Participants were not confident in the abilities of mental health service providers. When participants lacked faith in professional mental health treatment, they maintained their faith in God. When asked about potential treatments for depression, Mary, a 94 year-old African American woman responded: “I want to pray about it. I want you to talk to, you talk to God about it and he will guide, his Holy Spirit will guide you. But ah, people don’t put their trust in the Lord and he is over the doctor. He’s the one that over the doctor.” When asked if she had sought professional mental health treatment, one participant responded:

“No, because it didn’t, I wasn’t going to allow it to last, you know. Because I can get on the phone, with say, my sister, now we would pray, you know, and she would lift me up with the word of God, you know. So, no I figure I’d take it to the Lord, and he’d bring me out of it, you know? And that’s what I did, you know” (Joanna, a 67 year-old African American woman).

Another participant shared a similar belief:

“If my self-diagnosis was that I was depressed and I needed help, I’d get it. However if I just find myself with a touch of the blues, as many people do from [unintelligible], get over that. It’s not like drinking a Jack Daniels...either by doing it...my relationship with God, is that I have a problem, I go to him with a

problem. Hey Lord, look here, this is what's going on, let's work on this. And I turn it over to him...so, if that means working with professional help, I guess God's just as professional as you can get" (Gerry, an 82 year-old African American man).

Some participants felt that their ability to get over their depression was related to their amount of faith in God. Participants felt that this was something many African Americans believe. In the black community, faith and religion are very important and the experiences of being an African American and growing up in a community that turns to God with their problems lead to this avenue being a viable and culturally appropriate source for mental health treatment. Participants felt that God would heal their depression, but only if their faith was strong enough. For example:

"Well...I'm not sure that I have enough faith to do that. I think that if I take...if I pray about it, it all depends on my faith. And I think you have to say, you got to stay on your knees until you get enough faith, and you have to say, and remember when you're saying...it's not your faith, you have to have faith in God, that's a measure of your faith in God, about whether you can leave it there or not, so you have to say... I know there's an instance in the Bible where it says, 'Where is your faith?' And I say, 'Well what if I don't have the faith? It's not in me.' But then I start thinking, you have to remember...what you're really saying is, 'I have to have faith in God, you gotta have faith in what he says.' You know, so you're supposed to strive...and I pray that the Lord will increase my faith...increase mine...it's not mine, actually, in me, it's not even me to have enough faith, I have to have faith in God, and believe him. Believe what he says, believe his word. If I can believe his...if I can get strong enough to believe that what he says he means, and he's capable of doing what he says he can do...that I have to strive to have more faith than God" (Elise, an 82 year-old African American woman).

Outcomes for African American Older Adults With Depression

Participants identified a number of experiences living with depression in the African American community and discussed how this has impacted their attitudes about mental health treatment and their help-seeking behaviors. African American older adults learned cultural beliefs around the value of keeping mental health concerns to yourself, and not talking to other individuals about mental illness. They were socialized to fear mental illness and seeking mental health treatment due to a concern of stigmatization and a lack of knowledge about effective mental health treatments and the importance of mental wellness. These experiences led to a number of barriers to older adults' access to professional mental health treatment, and in turn older adults had to identify other coping strategies to engage in that were culturally relevant and acceptable. While faith in God and prayer are important aspects of healing, handling depression on one's own and attempting to push through it despite severe symptoms may not be the most effective strategies in reducing the burden of mental illness.

Therefore, as a result of their experiences in the black community, the identified barriers to seeking mental health treatment, and cultural coping strategies which may or may not be effective, there were a number of outcomes for African American older adults with depression that need to be addressed. These experiences, barriers, and strategies produced a vulnerable group of African Americans older adults who have a difficult time recognizing when they are depressed, and when they do, they choose to use different language to discuss it, or deny being depressed altogether rather than to try to find an effective method to treat it. There were no questions asked during the qualitative interview that were intended to gain information about outcomes of not seeking mental health treatment; rather this information emerged naturally from the data.

Frontin'

Participants talked a lot about frontin' and hiding one's mental health status. The word frontin' came directly from the statements of many participants. Frontin' is a word used to capture behaviors engaged in by study participants including hiding their depressive symptoms from other people, lying to their family members and friends about what how they felt and what they were really going through, and keeping their mental health status from others. These participants often felt that they did not need mental health treatment, and believed they would not have to deal with the issue of help seeking if no one knew they were suffering. For example:

“And I wasn't allowing anyone to help me, because how can you help somebody if they don't ask for help, or show that they need it. See, I had a front on. I had a good front” (Andrea, a 73 year-old African American woman).

Participants often participated in frontin' because they did not want to admit that they were depressed, did not want to get treatment for their depression, and did not want to deal with being depressed. Andrea, a 73 year-old African American woman, stated that when it comes to being depressed: “There is some people won't admit it. They will not admit that they are depressed. People said, ‘Oh, aren't you...’ No I'm not. I'm okay.” When asked if she talked to her family or friends about being depressed, Alison, a 72 year-old African American woman stated: “I don't do that, I keep it to myself.” Joanna, a 67 year-old African American woman expressed a similar sentiment. When asked the same question she responded by stating: “No, cause I, no because I always showed, you know, I'm trying to be bubbly, you know, I never let 'em know that I was down.” One participant talked about frontin' in terms of wearing a mask to hide one's depression:

“Folks got masks they wear, and they might be really...there’s a guy that comes along, blows his brains out; you never would have thought that he was depressed” (Gerry, an 82 year-old African American man).

Denial

Some participants went beyond frontin’ and hiding their depression, to lying to others and denying their depression to others and even to themselves. Participants felt that African Americans coped by denying being depressed and believing what they are going through is not related to mental health. Participants often felt that this denial was due to a lack of information and education about depression and other mental illnesses in the black community. Lilly, a 73 year-old African American woman stated: “I think they’re in denial and they don’t know what to do about it.” Many participants were still in denial during the interview process about being depressed. Many felt they were not depressed, despite being told that it was their high scores on the Patient Health Questionnaire that made them eligible to participate in the current study. When asked how she handled talking to her family about her depression, one participant stated:

“Um, not admitting it, you know, don’t admit it. And...I’d say denying, denying that, you know...that’s just like...some people just deny, period. Because I would argue. ‘Oh, I’m okay! I don’t need this and I don’t need that.’ Oh, I was asked, but I denied that I needed it [mental health treatment]” (Andrea, a 73 year-old African American woman).

For some participants, denying their depression was due to their role as a caretaker for others, and not wanting to worry their family members. Andrea, a 73 year-old African American woman stated: “I was isolating myself, and I became more of a caretaker. So nobody could see that I needed help, because why? The kids was a shield. I denied it to myself.” Another participant expressed a similar concern:

“No, I don’t talk to anyone about it, I just keep it myself, because I have children and grandchildren, but I don’t tell them. Because I don’t want them to worry. Because they have their own personal problems, so I keep mine to myself. I don’t discuss it. I just don’t feel like discussing it, you know? Because they can’t help, I don’t want to worry anyone. They might try to help if they could” (Margaret, an 85 year-old African American woman).

For other participants, denial of depression was often due to a fear of being stigmatized. When asked why she did not talk to her family about her depression, Samantha, an 80 year-old African American woman stated: “I didn’t want anybody to know.” When asked why, Samantha responded: “Well, I’d feel funny. Yeah, I been sick all the time. I feel funny just telling everybody I’m sick.” Some participants felt that families tried to hide mental illness in their family from others due to the stigma associated with having a mental illness:

“I don’t know why they don’t know about mental health, and people try to hide it, I imagine that the families don’t want people to know that their children are ill, but they don’t think of mental illness as ill, so we don’t know how to do” (Lilly, a 73 year-old African American woman).

Lack of Recognition

Some participants felt that it was hard to recognize that they were actually depressed. Participants talked about the experience of living in the black community, in that many people struggle and are stressed, and therefore it is extremely difficult to recognize when your sadness has crossed the line to a mental health disorder. Andrea, a 73 year-old African American woman stated: “Um, it was hard to just recognize at first... I was so busy being a provider, so I didn’t realize...you know, sometimes we don’t realize that we do need help.” Walter, a 75 year-old African American man stated: “You don’t know when you’re depressed.” Some participants

were able to recognize their depression, but hid behind something more socially acceptable, for example:

“So I put the grieving there, and whenever somebody would say something, it was the grieving that you met with me. And the depression was back there. And I’m saying that was my crutch. I would let you know that I was grieving, but the depression was the back door. And what I hid behind was the grieving. You don’t forget them, you just put them... ‘Oh, I’m okay’ and then it become okay. You’re not okay, but you say you’re okay. And if you keep saying that, and you’re telling people, they feel like, Oh, she’s okay” (Andrea, 73 year-old African American woman).

Language

When participants did talk about being depressed, many participants discussed using different words to represent what they were going through. For many participants, calling depression by another name reduced some of the stigma attached to having a mental health problem and helped them to feel better about themselves. Mary, a 94 year-old African American woman stated: “I don’t hear anybody mentioning depressed, really. They might call it something else, oh your nerves are bad or something.” One participant talked in more detail about how she expressed how she was feeling to her family and friends without specifically identifying she was depressed:

“Well, I think I put it...when I’m telling them that I’m depressed, I’m saying, you know, ‘I ain’t up for that, I ain’t into that right now.’ And I be telling them, ‘I’m not in the mood for this,’ or ‘Don’t hand me that,’ ‘This is a bad time for me,’ and ‘Don’t come to me with that.’ I said, ‘See you later, because I ain’t in no mood for that.’ That’s as much as I tell them about I’m depressed, ‘I’m not in the mood for that. I don’t say, I’m depressed’” (Elise, an 82 year-old African American woman).

Help for Everyone Else

One final theme that emerged from the qualitative data was the decision made by older African Americans with depression to seek mental health treatment for their grandchildren. Many participants talked about their tendency to put others above themselves, and to put the needs of their family members and friends above their own. This included physical health needs, food, clothing, and mental health needs. These sentiments were mostly endorsed by the women in the sample who were caregivers to their children who were unable to take care of themselves, or to their grandchildren who were unable to be taken care of by their own parents. Andrea, a 73 year-old African American woman stated: “I...I got help for everybody but me.” She stated that even when she was feeling down or low, she would keep up the facade and focus on her grandchildren. She stated that when she felt depressed:

“You put that in the back, and you keep pushing, and that’s what happened to me. I just kept taking on everybody else’s problems and everybody else’s and if anybody asked me, ‘Oh, I’m okay!’ And then at night, when everybody was going to sleep, that’s when I found out that...I’d have the crying spells, I’d had...I would have the crying spells and that’s when I felt like...Why aren’t anyone helping me?”(Andrea, a 73 year-old African American woman).

Participants often stated that as mothers, it was part of their duty to put their own problems on the back burner, and focus on the problems of their family members. Alison, a 72 year-old African American woman stated that when she was feeling depressed she would say to her children: “Oh, Mama’s alright, she can do that”, and then she would say to herself “Go suck a rock, keep your problems to yourself, don’t want to hear them.” Participants stated that even when their family members realized that they were suffering from depression, participants did

not want to take their offers of help. Participants often felt that by receiving help from their family, they were becoming a burden:

“I’m used to doing, doing for myself and doing things myself, and I don’t want to be was it not a burden, but I don’t want to be dependent on anybody else to do things for me. That makes, that’s one thing that makes me feel a little different. Than I would feel ordinarily, because I don’t want nobody doing things for me” (Rachel, an 85 year-old African American woman).

Despite their unwillingness to seek mental health treatment for themselves, participants were often willing to seek mental health treatment for their family. Participants were often willing to give mental health treatment one more chance for their children or grandchildren, even when they were unable to give treatment one more chance for themselves:

I took the kids to therapy...and here I was...I needed just as much help as they did, but I just did not realize it, or didn’t take the time. I was so busy being a provider, so I didn’t realize...you know, sometimes we don’t realize that we do need help. And they asked me, ‘Don’t you need help?’ ‘Oh no, I’m fine, I’m fine.’ Then when I get home at night, I realize, I’m not fine” (Andrea, a 73 year old African American woman).

A skilled clinician could utilize this opportunity as a way to engage older African American grandparents in treatment. For example:

“We went into sessions and the counselor, she got so she could talk to me...I didn’t realize it then...she was helping me also. Because, she wanted me to come to the sessions with the kids. And then her and I would have a discussion afterwards. So without my really being asked for the help, I got it. And she would ask me... how are the kids, because her technique was, if I talk about the kids, then she’ll eventually get to how I feel” (Andrea, a 73 year-old African American woman).

4.2.2 Summary of Qualitative Results

African American older adults with depression in the current study have lived with a history of discrimination, racism, and prejudice, and they lived in communities where they have learned to survive despite these oppressive circumstances. The experiences in the African American community have impacted participant attitudes about mental illness and seeking mental health treatment. African American older adults endorsed cultural beliefs that value keeping mental health status private and not talking to others about mental health concerns. African American older adults in the current study believed that it is harder to be an African American and have depression, and that they experienced greater stigma in the black community than in other communities, and that this stemmed at least partially from the lack of information about mental health in the black community.

Participant's experiences being an African American older adult with depression led to a number of barriers to seeking mental health treatment. Participants identified a great deal of stigma, both internalized and public. Participants had a lack of faith in treatment and felt that they were unable to access treatment. Participants had mistrust for mental health service providers, and felt that they were too old for treatment to be effective for them. Therefore, they engaged in a number of cultural coping strategies to deal with their depression including handling depression on their own, trying to push through it, and turning their treatment over to God. These experiences, barriers, and strategies, however, have led to a difficulty recognizing depression, and a choice to deny and hide depression rather than find an effective way to treat it among many study participants. However, participants were willing to seek mental health treatment for their grandchildren, creating a unique opportunity to engage older African Americans in treatment.

5.0 DISCUSSION

Although many studies have examined the association between race and attitudes about mental health treatment, fewer have examined the association between race and treatment seeking behaviors, and to date very few have addressed the impact of stigma on these relationships. Even fewer have examined these relationships in a sample of older adults with depression. This investigation presents data on the impact of stigma and race on the mental health treatment seeking attitudes and behaviors of older adults with depression. In this study, many of the hypotheses were at least partially supported by the results, while others interestingly were not. Further analysis revealed internalized stigma as a salient factor in the lives of older adults with depression and a significant mechanism by which race impacts attitudes towards mental health services. The following chapter discusses the results of this study in more detail and provides some preliminary justification for study findings. This chapter also integrates the quantitative and qualitative results sections to provide a well-rounded presentation of study findings. Following this integration, the limitations of this study are discussed. Subsequently, there is a presentation of the implications of the current study's findings. Implications are identified for both research and practice. This chapter concludes with a synthesis of the information presented in the results and discussion chapters to provide a cohesive story of the lives of older adults with depression and the impact of stigma on their experiences.

Attitudes Toward Treatment

The first hypothesis that mental health treatment seeking attitudes and behaviors differ by race was partially supported in the current study. The hypothesis that African American older adults would have less positive attitudes toward mental health services was supported. African American survey participants endorsed significantly less positive attitudes about mental health services than their white counterparts. While this finding is inconsistent with some other studies that have found no racial differences in attitudes about mental health treatment (Broman, 1987; Diala et al., 2000), the current study may have found divergent results for two reasons. First, this sample included African American and white older adults who may have more negative attitudes about seeking mental health services than younger adults. And second, attitude toward services was assessed utilizing the Attitudes Toward Mental Health Treatment Scale (ATMHT), a modified version of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) (Fisher & Turner, 1970). The modified ATMHT (Conner, Koeske, & Brown, 2006) includes questions related to racial and ethnic match and comfort seeking services from a therapist of a different race or of a different age group. These questions make this scale more culturally relevant and sensitive to the beliefs of racial and ethnic minorities, as well as to aging populations.

While the finding that African Americans had less positive attitudes towards seeking mental health treatment was significant, the mean differences between white and African American survey participants on the ATMHT scale were not strikingly large, suggesting that while statistically significant, this finding may not be clinically significant. Overall attitude scores for both African American and white survey participants reflected both positive and negative attitudes toward seeking mental health treatment. Further analysis of scores on the

ATMHT scale yielded additional information that aids our understanding of older adults' attitudes toward seeking mental health treatment. The majority of both African American and white survey participants stated that they did not fully trust mental health professionals. A large number of both African American and white survey participants knew individuals who had negative experiences with the mental health service delivery system. Additionally, both older African American and older white survey participants felt that in order for mental health treatment to be effective, your mental health practitioner must be of the same racial/ethnic background. Despite this sentiment, most African American and white survey participants stated that they would be willing to see a mental health practitioner from a different racial background, despite their belief that the therapy would not be as effective.

There were a number of racial differences on the ATMHT scale reflecting more negative beliefs about mental health treatment held by the African American survey participants in the current study. The majority of African American survey participants believed that mental health treatment was not the most effective way to reduce mental health symptoms. African American survey participants also largely believed that mental health professionals endorse negative beliefs about individuals with mental illness. More than half of the African American survey participants believed that professional mental health treatment is a last resort, and the majority would seek help from their friends or family first. Additionally, white older adults were more likely than their African American counterparts to feel comfortable seeing a mental health professional who was from a different racial background as well as seeing a therapist who was younger than them. This suggests that while white older adults have a higher comfort level for therapists who racially differ, African American older adults prefer a therapist who they feel they can relate to, one who is 'like' them.

Qualitative interviews with African American older adults suffering from depression provided additional information that helps to qualify this result. The African American interview participants in the current study endorsed negative attitudes toward seeking mental health treatment, which seemed to be related to their lack of faith in mental health treatment. This lack of confidence in mental health treatment partially stems from mistrust. Interview participants identified a lack of trust in mental health care providers, mental health treatment, and in the mental health service delivery system in general. This mistrust is in part due to the history of maltreatment and discrimination against minority clients by mental health professionals and the mental health service delivery system. This history has created fear and mistrust among racial and ethnic minorities and in particular racial and ethnic minority elders (DHHS, 1999, 2001; Snowden, 2003).

Interview participants' lack of trust in mental health service providers negatively impacted attitudes toward treatment. This finding is supported in the literature. Research suggests that African Americans generally believe that therapists lack an adequate knowledge of African American life and struggle to accept or even understand them. African Americans also fear misdiagnosis, labeling, and brainwashing, and believe that mental health clinicians view African Americans as crazy and are prone to labeling strong expressions of emotion an illness (Thompson, Bazile & Akbar, 2004). Studies of black populations have shown that high levels of cultural mistrust are associated with negative attitudes toward mental health service providers and premature termination from mental health treatment (Poston, Craine & Atkinson, 1991; Terrell & Terrell, 1984). Nickerson, Helms and Terrell (1994) found that African American students who had high levels of mistrust were less willing to seek mental health treatment and did not expect to have a positive therapeutic encounter.

In the current study, interview participants were even more likely to experience mistrust of the mental health service delivery system when their mental health service provider was from a different racial/ethnic background. Thompson, Bazile and Akbar (2004) found that mental health clinicians are generally perceived by African Americans to be older white males, who were unsympathetic, uncaring, and unavailable. Psychologists were described as elitist and too far removed from the community to be of assistance to most African Americans. Interview participants were also reluctant to trust providers not active in the African American community. This supports the notion that racial match may be important when working with older African Americans with depression. There is support for this finding in the literature. Whaley (2001) found that 70% of his sample participants believed that individuals are more comfortable with clinicians from their own ethnic/racial group, and that African Americans with severe mental illness favor culturally similar clinicians over white clinicians. Whaley (2001) also found that participants with high levels of cultural mistrust tended to agree that people prefer racially and ethnically similar clinicians over white clinicians, despite simultaneously endorsing the belief that white clinicians receive better mental health training and may be more effective in reducing their mental health symptoms. While there is no clinical evidence that racial dissimilarity negatively impacts treatment outcomes (Davis & Proctor, 1989), research has shown that racial match positively affects the therapeutic process leading to greater comfort, and lower rates of premature termination (Asbury, Walker, Belgrave, Maholmes, & Green, 1994; Davis & Proctor, 1989; Sue, Fujino, Hu, Takeuchi, & Zane, 1991).

Many racial and ethnic minorities express a preference for receiving mental health treatment from professionals of their own racial and ethnic background. African American interview participants in the current study expressed a preference for racial match, but also

expressed a preference for clinicians who were similar to them in age. This preference reflects a desire expressed by older African Americans to talk with a clinician who is ‘like’ them, someone they can relate to. Given the low numbers of racial minorities trained to deliver mental health services, and the low numbers of older adults still working past 65, many mental health systems will be unable to deliver race and age matched services. There is growing interest in making mental health care more culturally appropriate and responsive (Conner & Grote, in press; Takeuchi & Uehara, 1996). Due to the increasing number of older adults in our population, however, there also needs to be a push towards making mental health care more sensitive to the needs of our older adult population.

Help Seeking and Barriers to Treatment

The hypothesis that mental health treatment seeking behaviors differ by race was partially supported in the current study. Contrary to prediction, there were no significant differences by race on intentions to seek mental health treatment or on current engagement in mental health treatment. Neither African American nor white survey participants were likely to intend on seeking mental health treatment or be currently engaged in mental health treatment. However, African Americans were significantly less likely than their white counterparts to have ever sought mental health treatment. In fact, while the vast majority of African American older adults had never sought mental health treatment, the majority of white older adults had sought treatment at some point in their lives. These findings were consistent even when controlling for depressive symptoms and SES. Additional studies are needed to compare the relationship between race and mental health treatment seeking behaviors in both older and younger adults to see if there are differences by age.

The National Association of State Mental Health Program Directors' (NASMHPD, 2000) Presidential Task Force of Mental Health and Aging states that older adults remain the most under-served and inappropriately served population in mental health services. While 13% of the United States is constituted of individuals aged 60 and over, their use of inpatient and outpatient services falls below every other age group. Older adults account for only 7% of all inpatient mental health services, 6% of community-based mental health services and 9% of private psychiatric care. Additionally, less than 3% of all Medicare reimbursed psychiatric services are for the treatment of older adults (Mental Health and Aging Website, 2008; NASMHPD, 2000). This suggests that intention to seek mental health treatment is a problem for all older adults, but may have a more significant impact on older racial minorities who often have less access to resources than their white counterparts.

In the current study qualitative interviews with African American participants highlighted a number of barriers to seeking mental health treatment that are likely to impact both older African Americans and whites, which may account for the lack of racial differences on treatment seeking behaviors among older adults with depression. Transportation was identified as a barrier to seeking mental health treatment for interview participants. Older adults identified not having access to their own car or to public transportation, and many have to rely on family members or friends for transportation. Therefore, older adults may not have a reliable method of accessing mental health treatment. As the physical health of older adults deteriorates, they may not be physically able to attend outpatient mental health services. Unfortunately, there are not many mental health service providers who provide treatment in the homes of their clients. Older adults with serious mental illnesses may be particularly under-served in managed care programs. Many managed care plans lack the full array of community support and residential rehabilitation

options that older adults with serious mental illnesses require (SAMHSA, 2007). And many older adults with serious mental illnesses live in facilities that are not designed for people with mental disorders, such as assisted living facilities, or in facilities that may be poorly regulated and offer few services, such as board and care homes (SAMHSA, 2007). Therefore, physically disabled older adults are a group that are particularly vulnerable to depression and mental health concerns, yet have a very difficult time accessing appropriate mental health services (Choi and Gonzales, 2005).

Financial burden was another barrier identified by interview participants. Interview participants who lacked health insurance were concerned about their ability to afford mental health care. Others who had health insurance were not sure that their coverage expanded to mental health care services, and believed that the cost out of pocket would be too much of a financial burden to bear. Economic factors directly influence an individual's ability to access health and mental health care (Koenig, George, & Schneider, 1994). A large number of individuals aged 65 and older have a difficult time accessing mental health services due to financial limitations. Many older adults are retired and are living on a fixed and very modest income. Individuals 65 and over without adequate protection of employer-provided insurance or Medigap policies may have difficulty paying for their mental health care since Medicare only reimburses 50% of the cost of outpatient mental health care and does not pay for prescription drugs. Medicare beneficiaries may also be restricted in the number of sessions covered (Koenig, George, & Schneider, 1994). For many older adults, however, it is an issue of lack of knowledge. Choi and Gonzales (2005) found that older adults have a perception that mental health treatment is not affordable, and may not be aware of programs offered through Medicare and Medicaid that could pay for their treatment.

Participants in the current study identified knowing other individuals who had negative experiences when they attempted to get mental health treatment as a barrier to seeking mental health treatment. Many African American and white survey participants identified knowing individuals who had negative experiences with the mental health service delivery system per the Attitudes Toward Mental Health Treatment (ATMHT) scale. Having friends or family who have had negative experiences with mental health treatment can deter individuals from choosing to seek treatment themselves. Diala and colleagues (2000) found that prior to actual service use, African Americans' attitudes toward mental health treatment were comparable to, and in some instances more positive than their white counterparts. However, African Americans who had a demonstrated a need for service use and received services endorsed more negative attitudes about mental health services and were less likely to utilize them again than were whites with comparable needs and usage. African Americans often report experiencing and hearing about cold, condescending, arrogant interactions and have complaints about being unable to make a connection with their clinician (Thomson, Bazike & Akbar, 2004). This suggests that something is occurring when African American clients encounter the mental health service delivery system that may be different from the experiences of white clients. Evidence also suggests that these negative experiences impact not only the individual who had them, but the attitudes of the friends and family with whom they share their negative experiences (Diala et al., 2000). This is an issue that needs to be addressed in additional research.

Participant age also was identified as a barrier to seeking mental health treatment in the current study. In many cases, interview participants felt that depression was a normal part of aging and that mental health treatment would not be effective at reducing their depression symptoms. Choi and Gonzales (2005) suggest that society's and older adults' own ageism

leading to misunderstanding and a lack of awareness of mental health problems is the leading barrier to accessing mental health treatment for older adults. They suggest that older adults and their family members may be slow to recognize the need for professional mental health services and that many older adults believe that changes in their mood and behavior reflect the normal aging process. Other participants felt that at their age it was too late for them, and that the energy of mental health service providers would be better served working with younger adults. Older adults often view their mental health problems as being unworthy of professional treatment outside of their informal support systems (Ray, Racitit & MacLean, 1992). Additionally, as individuals age they have a greater tendency to accept current life situations as they are, and are less likely to strive to improve their emotional well-being (Horwitz & Uttario, 1998). This may explain why older adult participants in the current study were unwilling to seek mental health treatment for themselves, but were willing to give the mental health service delivery system a chance for their children or grandchildren. Interview participants often expressed a need to help everyone else but themselves. They recognized that they needed help, but were unable to accept treatment for their own depression, while simultaneously bringing their grandchildren to see a clinician on a weekly basis. For the older adults in the current study, it may be that while they believe mental health therapy to be effective for others, due to their older age and the learned acceptance of their current life situations, they believe mental health treatment will not be effective at reducing depression symptoms for them. Working to change older adults' beliefs with regard to this issue may be challenging, but will be crucial in attempting to engage older adults in mental health treatment.

The Impact of Stigma

The second hypothesis that perceptions of and experiences of stigma differ by race was partially supported in the current study. The hypothesis that African American older adults would experience more internalized stigma than their white counterparts was supported. These results are consistent with previous research, which suggests that African Americans are more concerned about mental illness stigma (Cooper-Patrick et al., 1997), are more likely to experience stigma about mental illness (Rush, 1998), and live in communities that may be more stigmatizing towards mental illness (Silva de Crane & Spielberger, 1981). Therefore, it is logical that in this sample older African Americans endorsed more internalized stigma than their white counterparts. Interviews with African American participants in the current study provide additional information to support this result. Interview participants felt depression was a personal weakness and often blamed themselves for not being able to get better on their own. They believed the need to see a mental health clinician was a sign of weakness and identified more shame and internalized stigma when they had to admit to themselves that they needed professional help.

Additional research supports this finding. Ray, Racitit and MacLean (1992) found that older adults often view their mental health problems as being undeserving of professional treatment, and consider their symptoms to be a sign of personal weakness, failure, and spiritual inadequacy. In their focus group discussions with African Americans, Thomson, Bazile and Akbar (2004) found that the need to seek psychotherapy was associated with weakness and diminished pride. This finding was particularly salient for older adults and men. This supports the finding in the current study that men endorse more internalized stigma than women. With the

lack of research on the expression of depression in men, this highlights the importance of engaging men in research to better understand their experiences with depression and stigma.

Interestingly, the hypothesis that African American older adults would perceive more public stigma than their white counterparts was not supported by the results. While African Americans had higher public stigma scores and there was a trend towards a negative relationship between race and public stigma, this relationship was not statistically significant. In order to understand this finding, it is necessary to report that the total sample reported moderate to high public and internalized stigma scores. African American older adult interview participants identified a number of stigmatizing experiences in their community. Participants identified a number of stereotypes about individuals with depression, including being considered violent, dangerous and crazy. Participants perceived that others thought them untrustworthy and believed they were treated differently by others due to their mental health status. Participants even identified experiences of being discriminated against for employment due to their depression. In the current study, the qualitative interviews were better able to identify perceptions of and experiences with stigma than the perceived devaluation and discrimination scale used in the survey. Therefore, this hypothesis may not have been supported in the current study because the public stigma scale utilized may not effectively capture the stigmatizing experiences of African American older adults with depression. This issue needs to be addressed in additional research.

Givens, Houston, Voorhees, Ford, & Cooper (2007) found that public stigma is greatest when involving employers, followed by friends and family. Additional studies suggest that individuals with depression expect stigma in the workplace (Roeloffs, Sherbourne, Unutzer, Fink, Tang, & Wells, 2003), and that there is real discrimination by employers against individuals suffering from depression (Glozier, 1998). This finding in the current study suggests

that both African American and white older adults perceive high public stigma, which is consistent with other studies that have addressed the experience of mental illness stigma in the elderly. Choi and Gonzales (2005) found that older adults and their families are wary of possibly negative reactions of neighbors and other acquaintances due to their mental health condition. They also identified perceived sense of shame and stigma surrounding mental illness as one of the most commonly identified barriers to seeking mental health treatment for older adults of all racial and ethnic backgrounds. This suggests that another reason this hypothesis was not supported in the current study is that both older African Americans and whites perceive a great amount of stigma, and therefore the racial differences are small. This needs to be examined in future research.

The third hypothesis that high levels of self-reported public and internalized stigma would be related to more negative mental health treatment seeking attitudes was partially supported in this study. For both African American and white older survey participants, a high level of internalized stigma was significantly related to negative attitudes about mental health treatment. This finding supports previous research that identifies an inverse relationship between stigma and treatment related attitudes and behaviors (Barney, Griffiths, Jorm & Christensen, 2005; Cooper, Corrigan and Watson, 2003; Leaf and colleagues 1987). While the relationship between internalized stigma and attitudes was significant for the total sample, this relationship was stronger and more negatively correlated among the African American participants. This finding suggests that in addition to being endorsed at a greater level, internalized stigma also had a greater impact on attitudes toward seeking mental health treatment among African American survey participants in the current study.

Depression Among African American Older Adults

Interview participants talked in depth about depression in the black community, which became the overarching framework for the qualitative results in the current study. Interview participants felt that the black community is not tolerant of individuals suffering from depression, or any other mental health problem. Interview participants believed that they were more likely to be stigmatized and stereotyped in the black community for being depressed than in any other community. Interview participants suggested that one reason for this is due to the belief that African Americans don't get depressed. They identified the belief that stress and struggle are normal occurrences in the African American community, and therefore one should be able to deal with these issues without attaining a mental illness. When an individual is not able to bring themselves out of their depression or "pull themselves up by their bootstraps" then others treat them negatively and stigmatize them for being depressed. Some interview participants felt that this stigma was in part due to a lack of support supports of depression as a medical illness. Research has shown that older African Americans do not support the biological etiology of depression (Givens et al., 2007). Lack of belief in the medical model of depression by African Americans can lead to greater stigma about depression and other mental health conditions that individuals assume one should be able to handle on one's own.

Another issue in the black community which leads to higher stigma and negative attitudes about treatment is the lack of information and education about mental health and effective mental health treatments in the black community. Interview participants felt that they were uninformed and often misinformed about depression and mental health in general. They stated that they were unaware of programs and services that can treat depression. Additionally interview participants felt that traditional mental health education campaigns are not targeted at their community and

that the information provided is such that they cannot relate to it. This lack of information often leads to negative attitudes and reduced help seeking behaviors simply due to a lack of understanding as well as a lack of awareness of opportunities available to them. This finding is supported in additional research. In their focus groups with African Americans, Thomson, Bazile and Akbar (2004) found that even educated participants reported they lacked knowledge on the signs and symptoms of depression and of what to do when they are experiencing an emotional crisis. This lack of information sent African American interview participants in the current study to churches and emergency rooms, as these were considered accurate sources of information and referral. And given the limited availability of geriatric mental health services, older clients with low education have even less access to accurate information about available services and programs. Interview participants felt that increased education in the black community would help to reduce the stigma of depression.

While there was a trend towards a relationship between higher perceived public stigma and more negative attitudes toward mental health treatment, for both African American and white survey participants, this relationship was not statistically significant. This suggests that internalized stigma may have a more pervasive impact on attitudes toward mental health treatment. African American interview participants identified a great deal of public stigma in the qualitative interviews, and levels of public stigma assessed by the PDD scale were high for white and African American participants in the current study. However, the level of public stigma was not significantly related to attitudes toward seeking mental health treatment. Therefore, it may be that it is not merely experiencing stigma from others that has a detrimental impact; rather, it is when one internalizes those negative beliefs held by the general public and applies them to oneself that has an impact on their attitudes. This is consistent with findings from other studies

highlighting the impact of internalized stigma on individuals with mental illness (Conner, Koeske & Brown, 2006). Due to the strong relationship between public and internalized stigma, it is logical to suggest, however, that reducing an individual's experience with prejudice, being stereotyped, and discriminated against by others would likely reduce their level of internalized stigma. This needs to be examined in additional research.

While there was a significant relationship between internalized stigma and intention to seek mental health treatment and a trend towards a significant relationship between internalized stigma and engagement in mental health treatment, these relationships were in the opposite direction than hypothesized. These findings suggest that older adults survey participants with higher levels of internalized stigma were significantly more likely to intend to seek mental health treatment. While there was a trend for them to be more likely to be engaged in mental health treatment as well, this relationship was not statistically significant in the current study. This suggests that instead of internalized stigma being a barrier to intention to seek mental health treatment, individuals with internalized stigma were more likely to intend to seek mental health treatment. This result diverges from other research studies, which have found that both greater perceived public stigma and internalized stigma reduced the likelihood of seeking help from all sources (Barney, Griffiths, Jorm & Christensen, 2005). One reason for this finding is that individuals in the current study with higher levels of internalized stigma were also more likely to have severe depressive symptoms per the Patient Health Questionnaire (PHQ-9). Therefore, despite their negative attitudes about seeking mental health treatment, and their high levels of internalized stigma, these individuals are also in greatest need and dealing with more severe depressive symptoms. They then are more likely to intend on seeking mental health treatment. These variables need to be further tested in a larger study.

While internalized stigma was related to increased treatment seeking behaviors, one of the most powerful findings in the current study is the low engagement of study participants in mental health treatment, and the low intention of study participants to seek mental health treatment in the future. In the current study with older adults endorsing moderate to moderately severe depressive symptoms, more than half had never sought professional mental health treatment. Additionally, very few intended on seeking mental health treatment in the future and even fewer were currently engaged in mental health treatment. The African American study participants were even less likely to be engaged in mental health treatment or to seek mental health treatment in the future. In fact none of the African American interview participants were currently engaged in treatment and only a quarter had ever sought mental health treatment. These findings are supported by additional population-based estimates on the lack of engagement in mental health treatment among older adults and African Americans (DHHS, 1999; 2001).

Cultural Coping Strategies

Interview participants identified a number of reasons why African Americans chose to not engage in mental health treatment. They acknowledged that in the African American community there are culturally appropriate strategies for handling mental health concerns, with seeking professional mental health treatment at the very bottom of the list. Interview participants felt strongly that mental health problems should be kept within the family, and that you do not share that information with others. And the lack of trust in mental health care providers yields them unattractive options for African Americans with which to share their deepest and darkest secrets. Additionally, interview participants largely felt that they could handle their depression on their own and that they did not need professional mental health treatment. Previous research has suggested that African American older adults have developed a tendency to rely on informal

support networks and to engage in self-care, and to avoid or delay seeking mental health treatment until the condition is too serious to ignore (Neighbors, 1986). This self-reliance is a product of being low income and not having many resources, which has conditioned many African American older adults to endure their illness rather than seek professional mental health treatment (Bailey, 1987).

Self-care, including prayer and solicitation of counseling from religious figures rather than a mental health professional, stems from older adults' and African Americans' strong emphasis on spirituality. In the current study, interview participants felt that not only did their lack of spirituality cause their depression, they also felt that only through spirituality and their relationship with God would they be healed. Participants felt there was power in prayer, and that consistent prayer would reduce their depressive symptoms. If prayer itself was not effective, participants would turn to clergy or to their pastors and ministers for spiritual guidance and emotional support. This is supported in numerous studies, which identify the role of spirituality in the life of older adults and racial and ethnic minorities. One study found that older, more religious African Americans reported the use of prayer as a way to cope with depression (Thompson, Bazile, & Akbar, 2004). Givens and colleagues (2007) found that in addition to prayer as a coping strategy, African Americans often believe that prayer can effectively heal depression. They also found that African Americans prefer seeking counsel from the church to seeking professional mental health treatment. In the current study, participants seemed to believe that talking to a pastor or minister about their mental health concerns was a form of seeking professional mental health treatment. Future research may need to be more clear in conceptualizing professional mental health treatment and may want to include seeking treatment

from church staff as it is a culturally appropriate mechanism to seek mental health treatment for many African Americans.

Not only did interview participants in the current study believe God was the answer to their improved mental health status, but in fact family and friends of participants pushed them to “give everything up to God” and to “let go and let God.” Participants often took the advice of their friends and family and followed the advice to seek help through these culturally accepted mechanisms. There was a clear connection between support and behavior in the current study. For example, when interview participants received support from their family and friends to seek counsel from the church, they sought counsel from the church. And when interview participants received support to talk to a mental health clinician, they were much more open to doing so. Most interview participants, however, believed they would not attain support from their family and friends to seek treatment from a professional mental health service provider. And to protect themselves from being stigmatized and ostracized from their family and friends, many chose not to seek mental health treatment due to the lack of support from their family and friends. Fear of being stigmatized by close family and friends can be one the most powerful barriers to seeking mental health care (Givens et al., 2007; Roeloffs et al., 2003). This is particularly relevant for older adults who may rely more heavily on their children for support and transportation to and from appointments. Choi and Gonzales (2005) suggest that family support and encouragement, especially from adult children, is the most instrumental linkage to minority older adults’ engagement in mental health treatment.

In addition to culturally appropriate mechanisms for dealing with depression, African American interview participants identified treatments they did not endorse. African American interview participants in the current study had a preference for counseling, as opposed to

medication, to deal with their depression symptoms. Participants were concerned about the addictive effects of antidepressants, and felt they did not want to take an additional pill. Furthermore, many interview participants did not endorse the biological model of mental illness, and therefore had a difficult time believing taking an antidepressant would be an effective strategy to symptom reduction. This finding has been documented in a number of studies. Givens and colleagues (2007) found that in addition to African Americans having less faith in the biological etiology of depression, African Americans were more likely to believe in the addictive properties of antidepressants, and were more optimistic about the effectiveness of counseling. Das and colleagues (2006) found African Americans also have a preference to seek mental health treatment from their church or a primary care physician. They call this an “unsettling irony” because while African Americans are more likely to seek help for emotional distress from a primary care clinician than from a specialty mental health care provider, in primary care depression is less likely to be detected in African Americans than in whites (Das et al., 2006). Additionally, primary care physicians are more likely than specialty mental health care providers to suggest an antidepressant for symptom reduction, a treatment that has been consistently identified as one older adults and African Americans feel is ineffective and invasive and that they would prefer not to take.

Outcomes for African American Older Adults with Depression

In addition to these preferences, African American interview participants in the current study preferred the term “counseling” to the term “psychotherapy.” They believed there was less stigma attached to that label. Labeling was an issue brought up quite frequently in participant interviews. Participants felt that the label attached to mental health treatment, and that having “depression” meant you had a “mental illness,” which deterred individuals from seeking mental

health treatment, even those who actually wanted to receive services. Labeling theory states that a psychiatric label activates negative images about mental illness that are applied to the individual by others or by the individual themselves. The resulting discrimination and internalized stigma can impact treatment seeking attitudes and behaviors (Link et al., 1989; Roeloffs et al., 2003).

The African American older adults in the current study experienced a number of barriers to seeking mental health care and endorsed cultural coping strategies that are oftentimes not effective in treating their depression. They also experienced a great deal of stigma in their community, and felt they have very few options in dealing with their mental health concerns. Therefore, in order to shield themselves from the label of mental illness and to keep themselves from encountering the professional mental health care system, many participants have resorted to other means. Many interview participants acknowledged that they hide their depression from others. They used the term “frontin” to characterize their choice to hide their depression and keep their symptoms away from others. Interview participants also lied to family and friends when they were asked if they were all right, and denied being depressed, at times even to themselves. They would rather suffer in silence, than to acknowledge to others that they were depressed. Because to do so would mean that they would have to do something about it, and with the barriers to seeking mental health treatment identified by this sample and the other cultural coping strategies being the only viable methods, it is understandable why participants chose this option.

Choi and Gonzales (2005) found that older adults would rather deny their depression to others and sometimes even to themselves rather than experience the intense stigma and shame associated with that label. When interview participants in the current study did open up to others about their emotional distress, they chose to use different language to express their feelings.

Instead of calling themselves depressed they used terminology such as “my nerves” or “stress”. For interview participants, these words did not activate the same negative connotations as depression and mental illness. Participants felt that removing the label from mental health treatment by either changing psychiatric terminology, or changing where one can receive mental health services, would increase engagement in mental health treatment.

The final hypothesis that the relationship between race and attitudes toward mental health services would be partially mediated by stigma was partially supported in this study. While this relationship was significantly partially mediated by internalized stigma, the indirect effect of public stigma was not statistically significant. This suggests that although both public and internalized stigma seemed to be related to attitudes about treatment from the perceptions of older African American interview participants, the true mediation mechanism may lie in how an individual internalizes stigma that directly impacts one’s attitudes toward mental health treatment. This finding is supported by additional research that reports the inhibitory effect of internalized stigma to be very strong. One study found that while both perceived public stigma and internalized stigma about help-seeking for depression were common and reduced the likelihood of help seeking from any source, internalized stigma may be more important than public stigma and the disapproval of others in predicting intentions to seek mental health treatment (Barney, Griffiths, Jorm & Christensen, 2005). Despite the non-significant indirect effect of public stigma on the relationship between race and attitudes among survey participants, the experiences of public stigma were salient to lives of the African American older adults interviewed in this study. In a larger more representative sample, the indirect effect of public stigma may be larger and more significant. Therefore, it is imperative that this model be further tested.

5.1 LIMITATIONS

The results of this study should be viewed within the context of several limitations. In attaining our sample of older adults with depression, we had great difficulty recruiting older African Americans into our study. While it took us only 2 months to attain 128 white older adults, it took close to 6 months to achieve a sample of 120 African American older adults. Once potential African American participants found out that our study focused on issues of depression and mental illness, they elected not to participate. It is likely that the individuals who chose not to participate in the current study had greater public and internalized stigma, which led to their reluctance to be surveyed. Therefore, the African Americans that participated in the current study may have had less stigma than the eligible population. Another limitation is examining racial differences in only African Americans and whites, which leaves out many other ethnic minority groups. Additionally, the African Americans and whites in the sample might be ethnically heterogeneous, which may have influenced some of the study findings.

In this study, we examined level of education and current income as markers of socioeconomic status; however, there were other variables not taken into account. Assets may be a better measure of wealth than income. Additionally, the size of households supported by income and wealth was not addressed. Since African Americans tend to have larger households and fewer economic resources, yet this factor may have impacted the disparity between African American and white use of mental health services (Conley, 1999; Oliver & Shapiro, 1997). The measures of service utilization focused exclusively on mental health care that was provided by a

physician or mental health professional. Prior research suggests that utilization studies can be enhanced by the inclusion of informal sources of receiving care, such as the church, family or friends (Pescosolido et al., 1998). This may be particularly true when studying individuals with low-income and racial and ethnic minorities who tend to utilize informal networks more frequently. Additionally, it would have been informative to include a measure of perceived need by the participants rather than inferred need by symptom severity and a measure of physical health and disability, particularly with an older adult sample.

Causal relationships cannot be inferred from this study because the results cannot address the causal ordering of variables and there are possible unobserved cofounders. The cross sectional nature of the study limits the ability to determine changes in treatment seeking attitudes and behaviors over time. Although our data are consistent with the proposed partial mediation model, longitudinal studies with larger samples are needed to better address threats arising from this time ordering issue. Additionally, all information received was by self-report, and with an older adults sample this creates potential recall bias and poor recall. Finally, the dependent variable is measured by a scale that was recently adapted, and the psychometric properties of the scale have not been tested in multiple samples. Despite these limitations, this study has several strengths. This study provides a unique look at the relationship among age, race, stigma and attitudes toward treatment that has not been addressed in the literature. Therefore, it provides us with a useful starting place to address these complex relationships. There is also a lack of research examining these variables among older adult adults. This study was able to attain a fairly representative sample of older adults in the Pittsburgh area. Attaining information that may facilitate timely access to mental health care in this population is an important addition to the literature and provides useful implications for social work research and practice.

5.2 IMPLICATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

Implications for Practice

Findings from this study yield five approaches for addressing the barrier of stigma: 1) clinical stigma reduction interventions, 2) therapist training in culturally competent strategies to address stigma, 3) psycho-education about depression and treatment options, 4) community based health education campaigns, and 5) integrating mental health treatment and primary care services.

This study suggests that it is important for clinicians to recognize the impact of stigma on attitudes toward treatment seeking, particularly internalized stigma. Internalized stigma may be a more useful and more malleable clinical indicator to monitor and attempt to change than public stigma or exposure to stigmatizing experiences. Internalized stigma adds to already significant barriers among the uninsured, elderly, racial minorities and underserved before they enter treatment. Significant work has been done to improve the quality of depression treatment for these populations; however, these efforts have not included integration of knowledge about the effects of stigma on treatment due to insufficient knowledge of effective strategies (Roeloffs, et al., 2003). Decreasing internalized stigma can be addressed as a treatment goal, or as the target of separate psychosocial intervention. Treatments might focus on helping the individuals to overcome self-endorsed aspects of stigma (Ritsher & Phelan, 2004). In addition, tailoring treatment for stigma reduction to different patient groups, such as older adults, African Americans and other racial/ethnic minorities, and those with co-morbid medical illness, may be an efficient and culturally competent strategy. If therapists can target and reduce internalized

stigma in treatment settings, they will likely improve client attitudes and increase treatment-seeking behaviors.

In addition to clinical stigma reduction interventions, this study also highlights the necessity of culturally competent providers and the importance of culturally competent care in general. Mental health care providers must receive consistent and ongoing training in cultural competency that goes beyond the one or two courses they took as a graduate student. Findings from this and other studies suggest there is something occurring during the interaction between African Americans and the mental health care system that produces negative attitudes toward seeking mental health treatment, exacerbates already present stigma about seeking mental health treatment and leads to their utilization of alternate cultural coping strategies that may not be effective. Increased cultural competency may facilitate the type of positive experiences necessary to improve the image of mental health treatment in the African American community, and decrease the negative impact of stigma (Thompson, Bazile & Akbar, 2004).

It is also important for clinicians to receive more general skills that reflect their competency in working with African American and older adult clients. This study suggests that African American older adults have a high level of mistrust toward mental health treatment and service providers. This becomes particularly relevant when seeing a clinician from a different racial/ethnic group, or a clinician that is much younger. Since the majority of African American older adults who seek mental health treatment will likely have younger white service providers, it is necessary that these providers be aware of this issue and be skillful in their ability to elicit patient preferences, and discuss patient concerns, decrease stigma and be sensitive to the needs of this population. Clinicians must also be skilled in their ability to help African American older adults open up about their depression and stop denying and frontin'. One strategy for working

with this population might be to address the issues of race and age up front and find out what concerns the client has for working with a clinician from a different racial/ethnic background or age group (Givens et al., 2007; Thompson, Bazile, & Akbar, 2004). Providers can use this as a way to develop a therapeutic relationship and enhance level of trust.

Knowledge of patient preferences can aid in tailoring interventions to reduce mental health disparities in this population. There are many approaches that have been effective in reducing some disparities in the depression treatment process and outcomes for racial/ethnic minorities. Some of these interventions include: case management, psycho-education, and socio-cultural tailoring of evidence-based interventions (Givens et al., 2007). It is important for clinicians to recognize the importance of socio-culturally tailoring interventions, also known as personalized care. For example, in working with depressed women of color, Miranda and colleagues (2006) utilized a culturally enhanced cognitive-behavioral therapy protocol developed by Munoz and Mendelson (2005). In this adapted version of CBT, they utilized providers from the same racial/ethnic background, included cultural inferences, sayings and values into the treatment process, and started with a psycho-educational engagement session to reduce stigma, enhance knowledge and build trust.

Research demonstrates that culturally adapted mental health interventions are just as effective, yet racial and ethnic minorities largely prefer the adapted interventions over the traditional intervention (Kohn et al., 2002). Evidence-based practice in the field is critical, and making socio-cultural adaptations to empirically supported treatments to enhance the cultural relevance of mental health care may be an effective strategy for working with racial and ethnic minorities (Conner & Grote, in press) and older adults. Another strategy suggests utilizing a psycho-educational approach that teaches patients and their families about the causes and courses

of various psychiatric and medical illnesses. By attributing mental illnesses, such as depression, to a genetic vulnerability that is often exacerbated by stress, it guards against blaming the victim and self-blame, thus reducing stigma.

An additional way to help older adults attain knowledge and access to information about mental health while reducing stigma in the community is through community wide health education campaigns (Pollio, North & Osborne, 2002). This study suggests there is a lack of knowledge and understanding about late life depression among older adults and their families, and there is a strong sense of shame and stigma associated with mental illness. Community-based health education interventions can provide accurate information about mental health symptoms and disorders in late life, effective mental health treatments, and how to access these treatments. Increased awareness and knowledge about mental health disorders and the availability and effectiveness of mental health treatments is fundamental to increasing older adults' service use (Choi & Gonzales, 2005). Choi and Gonzales (2005) also suggest that in order for these interventions to be effective, it requires the coordination of the currently fragmented systems of primary care, long-term care, aging services, and mental health care.

Such interventions can be effective for the general population and especially for racial/ethnic minorities. In the African American community, education campaigns should address common myths about depression and depression treatments, and should be targeted for this community by using images and language that are culturally relevant and sensitive. Campaigns should also include information on location and availability of services within that community as well as in satellite offices in other communities. Some African Americans may not want to seek mental health treatment in a community where they live, and will therefore seek help in other communities where they will feel less opportunity to be stigmatized. The

availability of these services, whether located at mental health centers in the community or satellite offices outside of the community would require aggressive advertising in the African American community to effectively reach this population (Thompson, Bazile & Akbar, 2004). For minority elders in particular, special outreach efforts are needed to reduce the fear and mistrust in the mental health system endorsed by this population. African American geriatric mental health clinicians need to be trained and hired. Due to the shortage of geriatric clinicians in general, this issue will require active recruitment of mental health clinicians, with an emphasis on identifying clinicians of color, to be trained as geriatric specialists. It is necessary that schools of social work integrate geriatric mental health content into their curriculum and actively encourage their students to be culturally competent in working with the mental health problems of older adults from all racial/ethnic groups (Choi & Gonzales, 2004).

This study suggests older adults experience a great deal of stigma, and that experiencing the label of ‘mental illness’ can become a barrier to seeking mental health treatment. This is consistent with other research which suggests stigma adversely affects treatment seeking attitudes and behaviors as well as acceptability of mental health services. Therefore, in order to engage older adults in mental health treatment, it is necessary to identify strategies to reduce the stigma of receiving treatment. Integrating specialty mental health care into the primary care setting could address this concern (Givens et al., 2007). Integrating mental health treatment into primary care reduces stigma in a number of ways. It removes the label of mental illness from treatment, because you are seeing a primary care physician who could be treating you for a number of different reasons. Therefore, no one else has to know that you are seeing the physician for a mental health concern as opposed to a physical health concern. Additionally, if an individual already has a relationship with their PCP, there is less fear of stigma and more trust.

Therefore, receiving treatment from that provider or being referred to mental health care in the same building may enhance the likelihood of compliance with treatment (Das et al., 2006).

There are still some concerns with integrating mental health care with primary care however. When having emotional distress, African Americans are more likely to seek help from the primary care setting than from specialty mental health centers. However, in primary care, depression in African Americans is less likely to be detected than it is in whites (Borowsky et al., 2000). Additionally, nationally representative studies suggest that African Americans are less likely than their white counterparts to receive effective care for depression in primary care (Harman, Shulberg, Mulsant & Reynolds, 2001; Wang, Berglund, & Kessler, 2000). Therefore, primary care physicians need additional training on diagnosing depression among African American older adults and may require greater skill training in working with a population that endorses a high amount of mistrust and stigma, utilizes different language to discuss their emotional state and tends to front or deny their depression.

In addition tackling the negative impact of stigma, this study suggests there are a number of additional barriers to treatment that clinicians may be able to have some influence over. Clinicians must work towards providing mental health treatment in the home. This is particularly important for older adults who have co-morbid medical conditions or disability, and cannot travel to a community mental health center. When this is not possible, providing clients with bus vouchers, or helping them receive transportation through a medical access transit system, will help to eliminate lack of transportation as a barrier to treatment. Additionally, using sliding fee scales, and helping clients identify programs through Medicare and Medicaid that will help pay for mental health services, may reduce the financial burden of seeking mental health treatment on older adults who are already living on a limited income.

This study suggests African American older adults have strong faith in God and in the power of religion to heal depression. Therefore, it is important for the mental health treatment community to develop relationships with the spiritual community and work with them to help engage older African Americans into mental health treatment. It may also be important for mental health service providers to acknowledge the role of prayer and religion in the lives of their African American and older adult clients, and allow their treatment to be influenced by spirituality (Givens et al., 2006). This might include playing spiritual music during treatment to relieve anxiety, praying with your client or allowing them to pray during the treatment, and recognizing prayer and church attendance as part of the treatment plan.

This study also suggests that while African American older adults may not be willing to seek mental health treatment for themselves, they are often willing to give professional mental health treatment a chance for their children and grandchildren. Clinicians must work to change older adult attitudes about mental health treatment and inform them of the high rate of success in reducing depression in this population. One strategy for doing so might be through the use of videotapes that address concerns relevant to African American older adults and the use of speakers who are also African American older adults. This method may be helpful in facilitating attitude change in this population (Primm, 2002). It is, however, difficult to utilize these strategies when you are unable to get older adults to engage in even a first mental health treatment session. One way of doing so would be to utilize their willingness to seek treatment for their grandchildren as an opportunity to bring them into treatment. By gradually pulling them into the therapeutic process with their grandchildren and developing a trusting relationship, clinicians may be able to effectively engage African American older adults into treatment.

Suggestions For Future Research

This study has implications for additional research that is needed in the field. According to this investigation there are four major areas, which represent a gap in the existing literature on stigma and depression. To narrow this gap, further research should focus on: 1) the continued empirical assessment of the complex interrelationships among perceived public stigma, internalized stigma, race, and mental health treatment seeking attitudes and behaviors, 2) develop and test strategies on facilitating attitude change among older adults followed by longitudinal studies that address how attitude change impacts mental health treatment seeking behavior over time, 3) the development and evaluation of community-based health education campaigns and psycho-therapeutic interventions to reduce mental illness stigma in clinical settings and in the community and to increase the utilization of mental health services, and 4) examining the impact of multiple stigmas experienced simultaneously on treatment seeking attitudes and behaviors, particularly among African American older adults.

This study found that African Americans are more likely to internalize stigma and have negative attitudes toward seeking mental health treatment. Further analysis revealed that higher level of internalized stigma was related to more negative attitudes toward treatment, and in fact internalized stigma partially mediated the relationship between race and attitudes toward mental health treatment. Interestingly, while there were racial differences in attitudes toward treatment there were no racial differences on intentions or engagement in mental health treatment, and public stigma did not have a significant impact on any of these variables, a finding that differs from previous research. Many hypotheses in the current study were either not supported or were significant in the opposite way than predicted. There is still a great deal to be learned about this

impact of stigma and race on treatment seeking attitudes and behaviors. It is imperative that the relationships between these complex variables be further examined in larger more representative studies with older adults and with individuals from more diverse racial/ethnic backgrounds.

Additional variables should be included within these studies. Gender emerged as a variable of interest in the current study. Internalized stigma was greater among the men in the current sample than among the women. While the number of men in the current study was relatively small, this finding is relevant due to the limited information we have about depression in men and their experiences with stigma. Additional research is needed to examine these gender differences and focus on the experience of men suffering from depression and other mental illness. In this study social support and social norms were powerful determinants of help seeking. There may be a buffering effect of social support on individuals suffering from depression or other mental illness. Research should also look at the Theory of Reasoned Action and the impact of stigmatizing beliefs and social pressures (social norms) on treatment acceptability among older adults. Future studies should additionally include measures of perceived need of care as well as measures of physical health and disability. Studies should also be broader in their conceptualization of mental health treatment, and include more informal treatment seeking methods such as the church and prayer.

In the current study older adults endorsed negative attitudes about seeking mental health treatment. Attitudes had an impact on intentions to seek treatment and engagement in mental health treatment. Therefore, it is important to work towards changing older adults' attitudes about receiving mental health services. Strategies for efficiently and effectively changing the attitudes of older adults need to be developed and tested. Subsequently, longitudinal studies that follow older adults over time will help to examine the impact of changes in attitudes on

treatment-seeking behaviors in older adults. These studies will aid in the development of a causal model of how stigma impacts treatment seeking attitudes and behaviors and of the importance of attitude change on mental health service utilization.

Identifying specific attitudes and beliefs about depression provides an opportunity to develop clinical and community-based interventions to reduce stigma and increase treatment utilization by those suffering from depression and other mental illnesses (Copeland, 2006). Such interventions can be effective for the general population and especially for racial and ethnic minorities. Research should begin to identify strategies to address internalized stigma as a therapeutic goal or as the target of a separate psychosocial intervention. Research must begin to develop and test an intervention to target and reduce internalized stigma that can be utilized efficiently by mental health service providers. If providers can effectively target and reduce internalized stigma in treatment settings, they will likely improve client attitudes, improve treatment compliance and retention, and increase treatment-seeking behaviors. Public education campaigns address stigma by replacing myths about mental illness with facts. Research has documented that individuals who are more informed about mental illnesses like depression are less likely to endorse stigma and discrimination and are more likely to have positive attitudes about mental health treatment (Corrigan & O'Shaughnessy, 2007). None of these stigma reduction strategies, however, have been empirically tested in the African American community or with older adult populations, both of which have been observed to endorse negative stigmatizing beliefs about depression and to have low mental health service utilization rates. It is necessary for researchers to develop interventions aimed at reducing stigma and increasing knowledge about mental health and depression. These interventions need to be targeted to the community they will be implemented in and be culturally relevant and sensitive. Once in place,

researchers must examine the impact of these stigma-buffering interventions on knowledge about mental health and mental health treatments, attitude toward seeking mental health treatment, intentions to seek treatment and engagement in treatment.

Research should further examine the impact of multiple stigmas experienced by African American older adults who are suffering from depression. Multiple stigmas are the result of experiencing the stigma of being a member of a racial minority group as well as having a mental health diagnosis and aging, which poses significant barriers and perpetuates disparities in mental health service delivery (Gary, 2005). Results related to whether multiple stigmas have an additive or multiplicative impact on a stigmatized individual have been mixed. It is possible that the effects of depression stigma are simply amplified in the context of one's exposure to additional stigmas (Semple et al., 2005) suggesting that the more stigmas you have the more significantly they will negatively impact an individual and become a barrier to seeking treatment. Conner & Rosen (in press) found in their study of depressed methadone clients that individuals who reported more stigmas were more likely to identify stigma as a significant deterrent to mental health treatment, suggesting an additive affect. However, it is also possible that the multiple stigmas of race, depression and aging interact in a more complex way, working together to significantly affect the psychological well-being and treatment seeking behaviors of African Americans (Crandall, 1991), such that the experience of an additional stigma like co morbid health condition stop having as powerful an effect on treatment seeking attitudes and behaviors. These hypotheses need to be examined in future empirical research.

5.3 CONCLUSION

This mixed methods study examined the impact of stigma on racial differences in treatment seeking attitudes and behaviors among older adults with depression. Results suggest that while stigma among older adults is fairly high, African American older adults endorsed higher levels of internalized stigma and less positive attitudes toward seeking mental health treatment than their white counterparts. In addition, high levels of internalized stigma were related to more negative attitudes towards treatment and in fact partially mediated the relationship between race and attitudes toward seeking mental health treatment. Treatment seeking attitudes and behaviors was critically low for African American and white older adults. Older African Americans in the current study identified a number of experiences living in the black community that impacted their treatment seeking attitudes and behaviors, which led to their identification and utilization of more culturally endorsed coping strategies to deal with their depression. These experiences and barriers have produced a vulnerable group of older African Americans who tend to hide their symptoms and deny their depression to others, and at times even to themselves. Findings from this study provide a greater understanding of the stigma associated with having a mental illness and its influence on attitudes toward mental health services. Findings also provide insight to the factors impacting intentions to seek treatment as well as engagement in mental health services among older adults, particularly African American elders. This understanding will aid social work practitioners in targeting and reducing the stigma associated with having depression, which will likely improve attitudes toward mental health services and increase treatment-seeking behaviors among older adults.

APPENDIX A

TELEPHONE SURVEY PROTOCOL

1. Patient Health Questionnaire (PHQ-9)
2. Additional Screening Questions
3. Perceived Devaluation and Discrimination Scale (PDD)
4. Internalized Stigma of Mental Illness Scale (ISMI)
5. Attitudes Toward Mental Health Treatment (ATMHT)
6. Intention to Seek Treatment for Depression
7. Engagement in Mental Health Treatment

Patient Health Questionnaire (PHQ-9)

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

Not at all	Several Days	More than half the days	Nearly Every Day
0	1	2	3

1. Little interest or pleasure in doing things.....1 2 3 4

2. Feeling down, depressed or hopeless.....1 2 3 4

3. Trouble falling or staying asleep, or sleeping too much.....1 2 3 4

4. Feeling tired or having little energy.....1 2 3 4

5. Poor appetite or over-eating.....1 2 3 4

6. Feeling bad about yourself-or that you are a failure
or have let yourself or your family down.....1 2 3 4

7. Trouble concentrating on things, such as reading the newspaper
or watching television.....1 2 3 4

8. Moving or speaking so slowly that other people could have noticed,
or the opposite, being so fidgety or restless that you have been moving
around a lot more than usual.....1 2 3 4

9. Thoughts that you would be better off dead or of hurting yourself
in some way.....1 2 3 4

10. If you checked off any problems from this list, 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
0	1	2	3

Additional Screening Questions

1. Did a doctor ever prescribe Lithium, Depakote, Tegretol or Lamictol for you for a nervous or medical condition?

1. Yes
2. No

2. Has a doctor or health professional ever said that you had mania, manic-depressive illness, or bipolar disorder?

1. Yes
2. No

[If yes to question #1 or #2 probable bipolar disorder, ineligible for study]

3. Have any of the following happened to you more than once in the past 6 months?

1. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health (1. Yes 2. No)
2. You drank alcohol, were high from alcohol, or hung over while you were working, going to school or taking care of children (1. Yes 2. No)
3. You missed or were late for work, school or other activities because you were drinking (1. Yes 2. No)
4. You had a problem getting along with other people while you were drinking (1. Yes 2. No)
5. You drove a care after having had several drinks or after drinking too much (1. Yes 2. No)

[If yes to any questions #1 through #5, probable substance abuse, ineligible for study]

4. In the past 6 months, have you used marijuana?

1. Yes
2. No

5. Other than marijuana, have you used any other drugs such as crack, heroin ect.

1. Yes
2. No

[If yes, go to question #6, if no they have passed the eligibility criteria]

6. In the past 6 months, have you seen a health professional for marijuana or other substance use?

1. Yes
2. No

[If yes, ineligible for the study, probable substance use]

[If no, they have passed the eligibility criteria]

Perceived Devaluation and Discrimination Scale (PDD)

This scale contains statements about your perceptions of how the general public views people with depression. Please indicate whether you agree or disagree with each of these statements by circling a number on the scale ranging from 1 (strongly disagree) to 4 (strongly agree) that most honestly reflects your true opinion.

	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4
1. Most people would accept a person with depression as a close friend.....	1	2	3	4
2. Most people believe that a person who has depression is just as intelligent as the average person.....	1	2	3	4
3. Most people believe that a person with depression is just as trustworthy as the average citizen.....	1	2	3	4
4. Most people would fully accept a person with depression as a teacher of young children in a public school.....	1	2	3	4
5. Most people believe that having depression is a sign of personal failure.....	1	2	3	4
6. Most people would not hire a person with depression to take care of their children, even if he or she had been well for some time.....	1	2	3	4
7. Most people think less of a person who has depression.....	1	2	3	4
8. Most employers will hire a person with depression if he or she is qualified for the job.....	1	2	3	4
9. Most employers will pass over the application of person with depression patient in favor of another applicant.....	1	2	3	4

10. Most people in my community would treat a person with depression just as they would treat anyone else.....1 2 3 4

11. Most people would be reluctant to date someone who has been depressed.....1 2 3 4

12. Once they know a person has depression, most people will take his or her opinions less seriously.....1 2 3 4

Internalized Stigma of Mental Illness Scale (ISMI)

This scale contains statements about your beliefs of how you feel about being depressed. Please indicate whether you agree or disagree with each of these statements by circling a number on the scale ranging from 1 (strongly disagree) to 4 (strongly agree) that most honestly reflects your true opinion.

	Strongly Disagree	Disagree	Agree	Strongly Agree
	1	2	3	4
<hr/>				
1. I feel out of place in the world because I am depressed.....	1	2	3	4
2. Stereotypes about depression apply to me	1	2	3	4
3. People discriminate against me because I have depression.....	1	2	3	4
4. I don't talk about myself much because I wouldn't want to burden others about my depression.....	1	2	3	4
5. I feel comfortable being seen in public with an obviously depressed person.....	1	2	3	4
6. Having depression has spoiled my life.....	1	2	3	4
7. People can tell I have depression by the way I look.....	1	2	3	4
8. Others think I can't achieve much in life because I have depression.....	1	2	3	4
9. Because I have depression I don't socialize as much as I used to because my depression might make me look or behave weird.....	1	2	3	4
10. In general, I can't live my life the way I want to because I have depression.....	1	2	3	4

11. Because I have depression, people without depression can't possibly understand me.....1 2 3 4
12. Depressed people tend to be violent.....1 2 3 4
13. People ignore me or take me less seriously because I have depression.....1 2 3 4
14. Negative stereotypes about depression keep me isolated from the 'normal world' because I have depression.....1 2 3 4
15. I have a good, fulfilling life, despite having depression.....1 2 3 4
16. I am embarrassed and ashamed to have depression.....1 2 3 4
17. Because I have depression, I need others to make most decisions for me.....1 2 3 4
18. People patronize me and treat me like a child because I have depression.....1 2 3 4
19. Because I have depression, I stay away from social situations to protect my family or friends from embarrassment.....1 2 3 4
20. People with depression make important contributions to our society.....1 2 3 4
21. I am disappointed in myself for having depression.....1 2 3 4
22. People with depression cannot live a good, rewarding life.....1 2 3 4
23. Nobody is interested in getting close to me because I have depression.....1 2 3 4
24. Because I have depression, being around people who didn't have depression makes me feel out of place or inadequate.....1 2 3 4

25. Living with depression makes me a tough survivor.....1 2 3 4

26. Because I have depression, I feel inferior to others who don't have
depression.....1 2 3 4

27. Depressed people shouldn't get married.....1 2 3 4

28. Because I depression, I would avoid getting close to people who don't have
depression to avoid rejection.....1 2 3 4

29. Because I have depression, I wouldn't be able to contribute anything to society...1 2 3 4

Attitudes Toward Mental Health Treatment (ATMHT)

This scale contains statements about your attitudes and beliefs about seeking professional mental health treatment from a psychiatrist, psychologist, social worker or counselor. Please indicate whether you agree or disagree with each of these statements by circling a number on the scale ranging from 1 (strongly disagree) to 4 (strongly agree) that most honestly reflects your true opinion.

Strongly Disagree	Disagree	Agree	Strongly Agree
1	2	3	4
1. Professional mental health services can effectively reduce mental health problems.....			1 2 3 4
2. If I sought mental health services, it is likely I would find a therapist that I would feel comfortable opening up to.....			1 2 3 4
3. In my community, people take care of their emotional problems on their own; they don't seek professional mental health services.....			1 2 3 4
4. Mental health professionals are well trained.....			1 2 3 4
5. If I were experiencing a mental health breakdown, I am confident that taking medications would provide me with relief.....			1 2 3 4
6. I do not fully trust mental health professionals.....			1 2 3 4
7. I feel confident that I could find a therapist that is understanding and respectful of my ethnicity/culture.			1 2 3 4
8. Mental health professionals don't really care about you, they are just there for a pay check.....			1 2 3 4
9. Due to time and financial constraints, seeking mental health services is not			

- a feasible option for me.....1 2 3 4
10. Professional mental health treatment would not be helpful for me.....1 2 3 4
11. My family would support me seeking professional mental health services.....1 2 3 4
12. Mental health services are only effective if your therapist matches your race and/or ethnicity.....1 2 3 4
13. Most therapists have a lot of book smarts, but no street smarts.....1 2 3 4
14. I would be comfortable seeing a therapist that is a lot younger than me.....1 2 3 4
15. I believe that therapy is the most effective way to deal with mental health problems.....1 2 3 4
16. Most mental health professionals have negative beliefs about the mentally ill.....1 2 3 4
17. Seeking professional mental health services is a last resort.....1 2 3 4
18. I would be comfortable seeing a therapist that is of a different race than I am.....1 2 3 4
19. I know people who have had negative experiences when they sought professional mental health services.....1 2 3 4
20. I would seek help from my family and friends, before seeking help from a mental health professional.....1 2 3 4

Intention to Seek Treatment for Depression

1. During the next month, I intend to speak or meet with a health professional to discuss my symptoms of depression.

extremely unlikely	unlikely	unsure	likely	extremely likely
1	2	3	4	5

Engagement in Mental Health Treatment

1. At any time in the past, have you ever visited a health professional (psychiatrist, psychologist, social worker, mental health counselor, or primary care physician for a problem with your emotional or mental health professional?

1. Yes

2. No

2. If yes, when was your most recent visit?

Within the past month 1-6 months ago 7-12 months ago more than 12 months ago

1

2

3

4

3. Are you currently receiving treatment for depression?

1. Yes

2. No

APPENDIX B

QUALITATIVE INTERVIEW PROTOCOL

This appendix includes the qualitative interview protocol that was utilized in the interviews with older African Americans participants with depression. This protocol is semi-structured and probes were often utilized to get more in depth information about participant experiences.

Semi-Structured Interview Questions

Public Stigma

1. Were you afraid to tell anyone that you had depression?
 - a. What did you think people's reactions were going to be?
 - b. Where did you get the idea that people might react negatively?
2. What is stigma?
 - a. Do you think there is a stigma about having depression or being depressed?
 - b. Do you think there is a stigma about having a mental illness? Is it different from the stigma associated with depression?

Internalized Stigma

3. How has stigma affected you since you found out that you had depression?
 - a. Has stigma affected your decisions about whether or not to seek treatment?
 - b. Has stigma affected your decisions about where to seek treatment?
 - c. Has stigma affected your decisions about what kind of treatment provider you wanted to see? (For instance their profession, race or gender).
 - d. Has stigma affected how you see yourself?
4. Are there stereotypes out there about depressed people?
 - a. Do you believe the stereotypes are true? (About yourself or about other people w/ depression)
 - b. Do you think that society at large believes the stereotypes?

Multiple Stigma Effect (Race, Aging and Depression)

5. Do you believe your age affects your experiences with the stigma of depression?
6. Has living through the Civil Rights Movement and Tuskegee affected your attitudes about seeking mental health treatment?
7. Do you think it is harder to be an African American AND have depression? How?
 - a. Do you think society stereotypes you more or treats you more harshly because you are a minority with depression?\
8. Do you believe that the African American community is more or less stigmatizing about mental illness than the majority community?
9. Is depression more or less accepted in the African American community?
 - a. Is mental illness in general more or less accepted in the African American community?

Personal Experiences with Stigma

10. Have you had negative experiences in your community due to your depression?
 - a. Have you had negative experiences in treatment or in your attempting to seek treatment that you believe is due to your depression? (Or due to your race? Due to your age?)
11. If and when you sought treatment for your depression, did you drop out of treatment pre-maturely? Why? What could they have done to keep you in treatment?

Other Barriers to Treatment

12. Other than stigma, what were other barriers to getting help for your depression?

APPENDIX C

TELEPHONE SCRIPT

This appendix contains the verbatim telephone script that was utilized by the University Center for Social and Urban Research (UCSUR) when they conducted the random digit dialing telephone surveys and identified African American older adults who were willing to be contacted at a later time to potentially engage in qualitative interviews.

Telephone Script:
Treatment Seeking Among Older Adults With Depression

Hello, this is (name) from the University of Pittsburgh. We're calling people in the community to see if they might be interested in participating in a research study. We obtained your name from a directory of people in your area. Would you be interested in hearing more about our study and are you at least 65 years of age or older?

Y: (continue below)

N: *Is there another time that I could reach you that would be more convenient?*

Y: Date/Time_____

N: *Thank you for your time, good bye.*

Please let me tell you a little more. We are currently seeking individuals aged 65 and older from the general community who may be having some symptoms of depression to participate in a new research study. The goal of our study is to get a better understanding of stigma, and its impact on people's treatment seeking behaviors and attitudes toward seeking treatment in general. We hope that the knowledge gained from this study will help to improve our understanding of the stigma of depression, so that we can develop clinical and community based interventions to reduce depression stigma and increase treatment utilization for depression in the community. There is no cost to participate in our study. Those who are found eligible through this phone call, and complete this telephone survey (which should take approximately one half hour), will receive \$15 for their time. Are you interested in hearing more and possibly participating in our study?

Y: (continue below)

N: *Than you for your time, good bye.*

Before we enroll you in our study. We need to ask you a few questions to make sure that you are eligible to participate. These include questions about mental health and drug and alcohol use; this will take about 5-10 minuets to complete. I want to stress that we keep all responses confidential. We are only going to ask you for your name and address so that we can send you your check for \$15 as your payment for completing this study. We always separate a person's answers from his/her name and contact information so that no one is able to link someone's identity to the answers they give. We keep all of our records in secure office areas and on secure computer bases that are accessible only to research staff. And as soon as we send you your \$15 check, your contact information will be destroyed. Do you have any questions before we move on?

Please allow me to tell you a few more important things. If you agree to participate in our telephone survey, your participation is completely voluntary. You always may refuse to answer any questions if they make you uncomfortable, or for any reason. You always have the right to withdraw from the screening and from the study at any time, without penalty. There is no direct benefit to you for participating in the telephone screening and the risk to you is minimal. You will not be paid for completing this telephone screening, however if based upon this screening you are found to be eligible to take our telephone survey, you will receive \$15 through the mail after completion of the survey. This survey will take approximately 30 minuets and we can do it

immediately following the screening questions, or we can schedule another time to do the telephone survey.

The principal investigator for this study is Kyaien Conner of the University of Pittsburgh school of social work. If you have any questions I cannot answer, you have the right to call her directly at 412-383-1046. If you have any questions about research participation in general, or your rights as a research participant, you may also call the Human Subject Protection Advocate for the University of Pittsburgh Institutional Review Board at 1-866-212-2668.

Do you give us permission to ask you a few screening questions to see if you might be eligible for this study?

Y: (continue below)

N: Thank you for your time today, good bye.

Proceed to Screening Interview

1.) The following questions will make sure that you are eligible to participate in this study. These include questions about mental health and drug and alcohol use. This will take about 5-10 minuets to complete. (Administer the PHQ9).

[Cut-points have been established that correspond to minimal (score 1-4), mild (score 5-9), moderate (score 10-14), moderately severe (score 15-19), and severe

(score 20-27). If they have at least a score of 5, they will be eligible to participate in this study, and you can go on to the next statement.]

*** If a respondent scores above a 10 on the PhQ-9, or indicates thoughts of hurting themselves, or requests a referral, you must refer to respondent to mental health services at Western Psychiatric Institute and Clinic or to their local community based mental health center.***

If they do not meet the criteria: *I am sorry, you are not eligible to participate in this study. We sincerely thank you for your time today, good bye.*

Proceed to Administer Survey Questions

2.) *This next set of questions will ask you about certain personal characteristics such as your age, gender, race, marital status, education, employment status, and total family income.*

This will take about 5 minutes to complete.

(Administer Demographic Characteristics Survey).

3.) *This next section contains statements about your perceptions of how the general public views people with depression. Please indicate whether you strongly disagree, disagree, agree or strongly agree with each of these statements. Again, your responses are*

completely confidential so please answer in a way that most honestly reflects your true opinion. This will take about 5 minuets to complete.

(Administer the Perceived Devaluation and Discrimination Scale-Depression)

4.) This next section contains statements about your beliefs about having depression. Please indicate whether you strongly disagree, disagree, agree or strongly agree with each of these statements. Again, your responses are completely confidential so please answer in a way that most honestly reflects your true opinion. This will take about 5-10 minuets to complete.

(Administer the Internalized Stigma of Mental Illness Scale-Depression)

5.) This section contains statements about your attitudes and beliefs about seeking professional mental health treatment. Please indicate whether you strongly disagree, disagree, agree or strongly agree with each of these statements. This will take about 5 minuets to complete.

(Administer the Attitudes Toward Mental Health Treatment Scale)

If Respondent is NOT African American, the survey ends here. You can thank them for their time, get their address to send their \$15 payment, and answer any questions they may have.

If Respondent IS African American, proceed to asking if they would be willing to participate in an in-depth interview at a later time.

Thank you so much for your participation in our telephone survey. We have greatly appreciated your time today. Before we end this conversation we would like ask if you would be interested in participating in an in-person one-on-one interview at a later time to discuss similar questions as those asked in this telephone survey. The purpose of this interview would be to get more detailed information about your personal experience with these issues. The interview will be completely confidential. If you agree to participate in a one- on- one interview, your participation is completely voluntary and you always may refuse to answer any questions if they make you uncomfortable, or for any reason. The one- on- one interview will last approximately one hour, and you will receive \$50 for your time.

Are you interested participating in a one-on-one interview?

Y: (continue below)

N: *Again, Thank you for your time, good bye.*

What we need is your name and a telephone number where you can be reached. At a later time, a researcher named Kyaien Conner from the University of Pittsburgh will call you to set up a one-hour interview at a time that is convenient for you. Can I please have your name and telephone number?

This completes our conversation today. Again, thank you so much for your participation in this study.

APPENDIX D

CODEBOOK

This codebook was developed by the lead research to aid in the process of qualitative data analysis. All interviews were transcribed and were in-vivo coded using the codes outlined and defined in this codebook.

Mental Health Treatment Seeking Among Older Adults With Depression:

Project Coding(2008)

Public Stigma

- Are there stereotypes out there about people who are depressed?
- Were you worried about telling someone that you were depressed?
- What is Stigma?

CODE	ACTUAL TERMS	DEFENITION
Stereotypes	Crazy, untrustworthy, unpredictable, dangerous, violent.	Method of categorizing groups of people based upon some visible characteristic.
Stigma	They treated me differently when I was depressed, People treated me like I couldn't do things anymore, Don't treat me like I am stupid just because I am depressed.	Real or perceived attitudes held about individuals with a mental illness held by the general public and the experience of stereotyping, prejudice and discrimination based upon membership in a stigmatized group.
Seeking Treatment Stigma	Why would anyone tell someone they are seeing a shrink, If you get treatment you do it when nobody is looking.	Experiencing stigma due to decision to seek mental health treatment.
Didn't tell anyone	I didn't talk to nobody about my depression, I kept my depression to myself, I didn't want my family to know that I was depressed, I hid my depression from my family.	The choice to not tell anyone that one is suffering from depression.
Cultural Beliefs	In the black community you don't talk about being depressed, In the black community we keep things like depression in the family, We need to pull ourselves up, Its normal for black people to go through	Beliefs about mental health that are valued in the black community.

	depression, Black people have more reason to be depressed due to our circumstances, Depression is not a medical illness, Black people don't get depressed,	
Crazy	That N---s crazy, If you are depressed than you must be crazy, They think you are crazy, I was afraid to tell cause I was worried about being called crazy.	A stereotype placed on individuals with a mental illness that relates to their being psychotic .
Dangerous	They think depressed people are dangerous or something.	A stereotype placed on individuals with a mental illness that relates to their dangerous and that individuals should be afraid of them.
Untrustworthy	Depressed people cannot be trusted, they think we are untrustworthy or something	A stereotype placed on individuals with a mental illness that relates to their inability to be trusted.
Fear	Black people are afraid to seek mental health treatment, we are afraid of mentally ill.	An unpleasant often strong emotion caused by anticipation or awareness of danger, or threat.
Support	Support	Didn't support my friend who had mental health needs, black people need to support those who need mental health treatment.
Unpredictable	Depressed people are unpredictable	A stereotype placed on individuals with a mental illness that relates to their being totally unpredictable.
Black Experience	Being black contributes to depression, The history of black people contributes to depression, Slavery has a psychological impact, Racism and depression create stress daily, If you're black you are looked down upon, Black society is a stigma, Haven't seen one black person in those depression advertisements – they're always white	The events that make up the conscious past of the black community.
Denial	I denied having depression, when they asked me if I was okay I said yes.	To deny being depressed to others and to oneself.
Frontin	I was frontin, I had on a good front, people got masks.	To hide depressive symptoms from family and friends.

Internalized Stigma

- Have you ever experienced internalized stigma?
- Has it affected how you see yourself?

CODE	TERMS	CODE DEFINITION
Stigma	Stigma, weakness, blame myself, feel bad about myself, embarrassed.	The internalization of the negative attitudes about mental illness held by the general public and the application of those beliefs to oneself.
Weak	Being depressed is a weakness, you are weak if you need to get treatment for depression	The experience of feeling a lack of strength in ones abilities to do something.
Blame	I blame myself for my depression	Believing that it is the fault of the individual that something negative has happened to them.
Embarrassment	Depression is embarrassing, Embarrassment	Feeling bad about oneself and how one appears to other people based upon having a certain condition or characteristic.
Strength	I am strong enough to handle depression, I have a lot of strength in me.	Feeling strong in ones ability to do something.
Self-reliance	Black people handle depression on their own, Black people can push through depression, Black people will just bounce back, Just deal with being depressed, believe in God, God can heal depression.	The ability to manage one's own affairs, make one's own judgments and provide for one's self.
Expectations of Self	I should be able to get through depression on my own.	Beliefs or assumptions about the capacities of one's self or others.
The 'label' of mental illness	The label stops us from seeking mental health treatment, We don't seek treatment cause they put that label on it, Anything with a label on it you run from it, If you get treatment you do it when no one is looking.	Experiences of stereotypes, prejudice and being discriminated against due to being labeled mentally ill

Multiple Stigma Effect (Race, Aging and Depression)

- Do you believe your race affects your experiences with the stigma of depression?
- Has living through Civil Rights and experiencing racial prejudice affected your attitudes about seeking mental health treatment?
- Do you think it is harder to be and African American AND have depression?
- Is depression more or less accepted in the African American community?

CODE	TERMS	CODE DEFINITION
Black Experience	Being black contributes to depression, The history of black people contributes to depression, Slavery has a psychological impact, Racism and depression create stress daily, If you're black you are looked down upon, Black society is a stigma, Haven't seen one black person in those depression advertisements – they're always white	The events that make up the conscious past of the black community.
History	The history of black people contributes to depression	Previous treatment, handling or experience
Slavery	Slavery has a psychological impact	Capture and enslavement of a group of people by a dominating influence.
Racism	Racism and depression create stress daily, If you're black and depressed you are worthless.	A belief that race is the primary determinant of human traits and capacities and that racial differences produce an inherent superiority of a particular race
Expectations	Black people should get over depression	Beliefs or assumptions about the capacities of one's self or others.
Culturally Informed Coping	Black people handle depression on their own, Black people can push through depression, Black people will just bounce back, Just deal with being depressed, believe in God, God can heal depression.	To deal with and attempt to overcome problems and difficulties in a manner consistent with one's cultural values.
Fear	Black people are afraid to seek mental health treatment, we are afraid of mentally ill.	An unpleasant often strong emotion caused by anticipation or awareness of danger, or threat.

Support	Didn't support my friend who had mental health needs, black people need to support those who need mental health treatment.	An act or instance of helping and/or being there for someone during distress.
Care taking	Got to care my grandchildren	One that gives physical or emotional care.
Expectations of Self	I should be able to get through depression on my own.	Beliefs or assumptions about the capacities of one's self or others.
Access to Information	Black people don't get the same information, there is a lack of education about mental health in the black community.	Information is not easily approached or readily available.
Relevance of depression advertisements	I can't relate to information about depression – those people don't look like me.	Information about depression that the user can relate to.
Cultural Beliefs	In the black community you don't talk about being depressed, In the black community we keep things like depression in the family, We need to pull ourselves up, Its normal for black people to go through depression, Black people have more reason to be depressed due to our circumstances, Depression is not a medical illness, Black people don't get depressed,	Beliefs about mental health that are valued in the black community.
Ageism	Depression is a normal part of aging, I am too old for depression treatment to work for me, why they wanna waste time on us old folk anyway.	Experiencing prejudice and discrimination by others or by the individual themselves base upon age.
Multiple Stigma	It is harder to be black and have depression, That N--- crazy, Depression is less accepted in the black community	The impact of experiencing multiple stigmas in society simultaneously.

Personal Experiences with Stigma

- Have you had negative experiences in your community due to your depression?
- Have you had negative experiences in attempting to seek mental health treatment?

CODE	TERMS	CODE DEFINITION
Public Stigma	Stigma, stereotypes, crazy	Experiences of stereotypes, prejudice and being discriminated against for being depressed.
Internalized Stigma	Stigma, weakness, blamed myself	Internalizing general public's attitudes about mental illness and applying them to oneself
Ageism	Depression is a normal part of aging, I am too old for depression treatment to work for me, why they wanna waste time on us old folk anyway.	Experiencing prejudice and discrimination by others or by the individual themselves based upon age.
PCP	PCP	Primary Care Physician
Social Worker	Social Worker	Any health care professional trained in providing mental health services and treatments.
Medication Concerns	Afraid of medications, Pills are not going to be my answer, I don't want to take any medication that is going to make me sicker than I already am, I don't take any pills from my doctor.	Concerns about taking medication for treatment of depression.
Counseling	Counseling conversation, Rather counseling than medications	Professional guidance of the individual by utilizing psychological methods.
Lack of recognition	Didn't recognize that I needed treatment, it is hard to tell when you are depressed, I didn't think I needed help.	Decision making process leading up to recognizing that you have depression.
Mental health Professional	Mental health Professional	Any health care professional trained in providing mental health services and treatments.

Other Barriers to Treatment

- Other than stigma, what were other barriers to getting help for your depression?

CODE	TERMS	CODE DEFINITION
The 'label' of mental illness	The label stops us from seeking mental health treatment, We don't seek treatment cause they put that label on it, Anything with a label on it you run from it, If you get treatment you do it when no one is looking.	Experiences of stereotypes, prejudice and being discriminated against due to being labeled mentally ill
Lack of confidence in Treatment providers	Doctors make too many mistakes, mental health people don't know what is goin on, I don't have confidence in their ability to know what to do with depression, Doctors are not God	Lack of belief in the ability of treatment providers to be efficacious.
Lack of faith in treatment	People with mental illness don't get help, Don't give me no treatment that is gonna make me sicker than I am, mental health treatment is a lack of good insurance money and a waste of my time.	Lack of belief in the effectiveness on mental health treatments for depression.
Transportation	Don't have a care, can't depend on my children to drive me back and forth to treatment, why can't people like you come an see us in our homes.	Difficulty accessing transportation to get back and forth to treatment.
Finances	In the black community people don't have the money, Black people can't afford to send them to see them and to treat them.	Difficulty obtaining the financial resources necessary to seek treatment.
Lack of Health Insurance	Not having insurance hinders people from getting help cause they don't wanna get rejected, they don't have the right insurance	Not having access to insurance that covers mental health treatment.

Mistrust	I don't trust nobody but me to deal with my depression, you can tell what people are about when you look them dead in the eye, especially white people, I don't believe too much in doctors	To be uncertain, disbelieving or skeptical about physicians and mental health clinicians.
Ageism	Depression is a normal part of aging, I am too old for depression treatment to work for me, why they wanna waste time on us old folk anyway, I figured at my age I am not gonna be around here for much longer anyway	Experiencing prejudice and discrimination by others or by the individual themselves base upon age.
Multiple Stigma	It is harder to be black and have depression, That N--- crazy, Depression is less accepted in the black community	The impact of experiencing multiple stigmas in society simultaneously.
Negative Experiences	They didn't help her in treatment any, You don't get much support in the mental health system when you are black.	Personally experienced experiences or third party experiences with the mental health system.
Isolation	Separate myself from church and family, Didn't go no where and didn't wanna talk to anybody.	Removing oneself from others as a behavioral reaction to depression.
Health Issues	Health issues, children with health problems, Medical illness, Getting sick a lot, Disability, Hard to walk,	Any illness, condition or situation leading to deterioration in the body, mind and spirit.
No cure for Depression	No cure for Depression	No treatments exist for the condition of depression.
Self-reliance	Black people handle depression on their own, Black people can push through depression, Black people will just bounce back, Just deal with being depressed, believe in God, God can heal depression.	The ability to manage one's own affairs, make one's own judgments and provide for one's self.

APPENDIX E

ATLAS.TI DESCRIPTION

This appendix contains a description of the ATLAS.ti computer program that was utilized by the lead researcher to aid in qualitative thematic data analysis. The lead researcher utilized his computer program to input all transcriptions into the computer program and to go in and code the data. The lead researcher was also able to separate all written words by the coded, which aided in the development of categories of data, sub-themes and ultimately of the broad themes presented in the qualitative results section of this study.

ATLAS.ti: Qualitative Data Analysis Computer Program

ATLAS.ti provides tools for qualitative analysis of large bodies of textual, graphical, audio and video data. You can manage, extract, compare, explore and reassemble meaningful pieces of data in creative, flexible, yet systematic, ways. Visually connect selected passages, memos and codes into building blocks of emerging models with ATLAS.ti's graphical network editor. ATLAS.ti is particularly well suited to work with social work research and will allow this author to conduct a thematic analysis of qualitative data from ethnographic interviews.

Features of ATLAS.ti include:

- Interactive and automatic coding of rich text, image, audio and video materials
- Visual model building with the graphical Network Editor.
- Create and navigate Hyperlinks to analyze threads of conversation.
- Powerful search & retrieve functions.
- Export projects to SPSS, HTML, XML, CSV
- Quantitative data options: SPSS, word frequency, and coding table export to Excel
- Teamwork support: project merge and migration, shared documents
- Peer-to-peer support: join the active ATLAS.ti mailing list

New and revised in ATLAS.ti 5.0

- Rich Text support with embedded active objects (Excel, images, etc)
- Use Word documents directly via on-the-fly conversion.
- Live editable documents with dynamic multi-project update.
- Improved East Asian and Middle East language support
- Fully interactive margin area with drag & drop linking, coding, merging
- The Object Crawler searches for textual patterns in the project
- Smart Super Families for powerful filters.
- Network Editor: auto-color node visualization
- Create impressive presentations using the XML/XSLT converter.
- Single file project backup and migration.

- Table based bulk assignment of primary documents plus attributes (families)
- Local and remote database access (Oracle, MySQL, etc.) to assign documents (enterprise version only)
- 400+ page manual in Adobe Acrobat PDF format provided on CD (reader included)
- and much more...

This information was retrieved on 4/3/06 from: http://www.psychologysoftwaredistribution.com/ATLAS_ti/atlas_ti.html

APPENDIX F

UNIVERSITY CENTER FOR SOCIAL AND URBAN RESEARCH (UCSUR)

DESCRIPTION

This appendix provides a detailed description of the University Center for Social and Urban Research (UCSUR). This group aided in the conducted of this research study in a number of ways. They utilized random digit dialing technique to recruit a sample of 248 older adults with depression and conducted the telephone survey. They additionally identified a number of African American older adults with depression who were willing to participant in the qualitative phase of this study. Additionally, the qualitative data analysis program housed within UCSUR transcribed the participant interviews conducted with 20 older African American.

The University Center for Social and Urban Research (UCSUR)

The University Center for Social and Urban Research (UCSUR) was established by the University of Pittsburgh in 1972 to serve as a resource for researchers and educators interested in the basic and applied social and behavioral sciences. As a hub for interdisciplinary research and collaboration, UCSUR promotes a research agenda focused on the social issues most relevant to our society, the psychosocial impacts of adult development and aging, and environmental resource management. In addition, UCSUR maintains a permanent research infrastructure available to faculty and the community with the capacity to:

- Conduct all types of survey research and data analysis.
- Carry out regional econometric modeling.
- Obtain, format, and analyze spatial data.
- Acquire, manage, and analyze large secondary and administrative data sets including Census data.
- Design and carry out descriptive, evaluation, and intervention studies.

A fundamental part of the Center's mission is to maintain first-rate survey research and electronic data processing capabilities. In keeping with this objective, UCSUR's Survey Research Program provides a quality survey research and data processing infrastructure, featuring a 24-station computer-assisted telephone interviewing (CATI) facility, which supports the Center's externally-funded research projects. The survey research program maintains a highly experienced staff of survey professionals, trained interviewers, and data management specialists. Survey research services are available to faculty, staff, and students throughout the University, and to local, state, and federal agencies and others working in the public interest. The survey research program at UCSUR is able to carry out any or all phases of a survey research project, including sample design, questionnaire design, data collection, data processing, statistical analysis, and reporting. UCSUR staff have the training and experience to design scientifically valid studies customized to client research needs.

What makes the survey research program unique at the University of Pittsburgh is the survey data collection infrastructure, including a 32-station computer-assisted telephone interviewing (CATI) facility, a pool of trained and experienced interviewers, and professional supervisory staff to ensure continuous quality control. This thirty-two line phone bank at UCSUR is dedicated to a computer-assisted telephone interviewing (CATI) system. Survey instruments are programmed into the system, and interviewers read questions as they appear on the screen and enter the respondent's answers directly into the computer. CATI allows complex question contingencies, sample management, and call scheduling to be handled automatically. CATI also affords the opportunity to incorporate randomized experiments (e.g., varying question order, question wording, response options) into surveys. In order to maximize response rates, calls are typically made on varying days of the week at different times to maximize the probability of contacting respondents, and attempts are routinely made to convert initial refusals into completed interviews. Data are automatically exported to a statistical analysis package and examined by programmer/data management specialists on a daily basis for additional quality control purposes.

The University Center for Social and Urban Research (UCSUR) has extensive experience conducting random digit dialing (RDD) to attain samples for research studies. Particularly suited for telephone surveys of the general population, randomly selected computer-generated telephone numbers, including both listed and unlisted, are used to target specific geographic areas. RDD sampling for any region of the United States is available (e.g., county, state, MSA, national). The survey research program at UCSUR uses software to draw RDD samples in-house, and also has the capability to target areas with particular demographic characteristics.

The University Center for Social and Urban Research (UCSUR) is also well suited to work with geriatric social work researchers. The study of adult development and aging has become a central focus of researchers and educators in almost every university in the United States. At the University of Pittsburgh, social science, medical, and legal expertise on aging issues can be found in virtually all schools and departments. These human resources are augmented by extensive research, service, and training facilities that provide both direct services to older adults in the Pittsburgh area and hands-on training to students and research fellows. The mission of the Gerontology Program at UCSUR is to act as a catalyst and coordinator for the multidisciplinary study of aging. In collaboration with faculty in more than a dozen different disciplines (e.g., Social Work, Psychiatry, Nursing, and Epidemiology), program faculty and

staff play an active role in the development of proposals for research focused on psychosocial, behavioral, cognitive, and physical aspects of aging. One of the principal goals of the Gerontology Program is to stimulate the development of externally funded research in the physical and mental health of older adults and cultural differences and aging. Therefore, UCSUR is a great resource for geriatric social workers and will be a great collaborator on my dissertation study that addresses stigma as a barrier to treatment seeking among older adults.

For more information about UCSUR, contact:

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APPENDIX G

MEMOS WRITTEN TO AID IN QUALITATIVE ANALYSIS

This appendix contains memos written to myself that aided in the process of qualitative data analysis. Memos are a key part of qualitative data analysis, in that they help to flush out ideas the research has about the data and aid in the connection of themes into a broader framework. These memos greatly enhanced the ability of the researcher to discuss the results in a clear and concise way that also greatly contributed to the literature.

Memo: Participant Experiences with Stigma

Date: March 10, 2008

Dear Kya,

I have been spending a lot of time reading through the transcripts and one of the things that keeps popping out to me is participant experiences with stigma. Their experiences are so salient and powerful and seem to have a significant impact on their attitudes toward seeking mental health treatment, which would make sense since I found that relationship to exist when looking at the larger sample of 248 older adults. One of the things that keeps being reinforced is the belief that if you are depressed than you must be crazy. Participants said this over and over again. I am wondering when it became acceptable in society to lump all people with a mental health condition into the crazy category. If older African Americans believe that to have depression is so to be crazy, then no wonder they don't want to have anything to do with that label and want to disassociate themselves from being depressed all together.

The older African Americans we surveyed seem to talk more about public stigma in the interviews than internalized stigma, although in the survey internalized stigma scores were high and internalized stigma was significantly related to attitudes about mental health treatment and public stigma was not. It makes sense to me that it may not be how one perceived others to believe but rather it is one the individual believes that impacts their treatment seeking attitudes and behaviors, but if that is the case then why are not more participants bringing up the issue of internalized stigma?

-KC

Memo: Internalized Stigma and “weakness”

Date: March 21, 2008

Dear Kya,

As I read more about participant experiences with stigma I find that it is not that African American older adults talk more about public stigma than internalized stigma. Rather, it is easier to recognize when someone is talking about public stigma than it is to recognize when and individual is talking about how they feel about themselves now that they have depression, because most people just don't talk about it that way. In the interviews, people often talked about what other people thought about individuals with depression. It is easy to point out the stereotypes attached to people with mental health conditions, they are crazy, dangerous, unpredictable, and untrustworthy. It is easy to point out when an individual says they got treated differently by their family and friends when they had depression, or even when they say people made them feel bad about needing to seek mental health treatment. But it is not easy to get people talking about how being depressed makes them feel about themselves.

In this study, it looks to me like although people don't use the word internalized stigma, they do use the term weakness. They say that the fact they are going through a depression is because they are weak and therefore they are unable to fight off the depression. This weakness is a part of who they are and therefore the depression makes them feel bad about who they are. This is why so many people talked about being strong enough to handle depression on their own, and that they had enough strength and willpower to get through this on their own. They were trying to protect themselves from experiencing internalized stigma by telling themselves that they are strong and not weak. I think when we look at internalized stigma with this population we should

use this terminology to reflect what we are really talking about. We also must find a way to help people recognize that getting professional mental health treatment does not mean that they are weak. It just means that they have a medical illness, that can only be helped with professional treatment. We would not expect someone with cancer to just handle it on their own, we would not expect someone with a broken leg to be strong enough to walk around on that leg and it should just get better on its own. So why do we accept this with mental health conditions?

-KC

Memo: Depression in the Black Community

Date: April 1, 2008

Dear Kya,

I have been thinking a lot about the experiences of being an African American older adult with depression in the black community and the way in which being African American impacts ones' experiences with depression and stigma. The African American older that we interviewed talked a lot about their experiences and identified some very powerful occurrences growing up an African American and in the black community, and how those experiences shaped a large part of their identity. They talked about the African American culture and how black people keep their mental health stuff to themselves. They don't go around talking to other people about the fact that they are depressed. These beliefs shaped their attitudes and beliefs about mental health. For example, many of the participants felt that depression is not a medical illness. Well, if you don't think depression is a real illness then why would you consider seeing a professional to fix it? You wouldn't. It seems that attitude change in the older adult population about the appropriateness of mental health treatment is important.

-KC

Memo: Depression in the Black Community and Barriers Health Treatment

Date: April 17, 2008

Dear Kya,

After talking with Dr. Rosen, I have been thinking more and more about how to pull these themes together in a way that makes sense. Now that I have been thinking about depression in the black community, I can better see the connection between this and barriers to seeking mental health treatment for African Americans with depression. Participant experiences dealing with depression as an African American and living in the black community seemed to have an impact on their attitudes about mental health services and negatively impacted their treatment seeking behaviors. There were a number of cultural beliefs identified that socialized African Americans to keep their mental health concerns to themselves. For example, they felt that African Americans should keep their mental health stuff to themselves and not talk about it with other people. They also felt that depression was not a medical illness, and therefore mental health treatment was not a reasonable option. And a lack of education and information about mental health in the black community led to stigma and fear. Participants felt that there was not enough accurate information in the black community about mental health nor effective mental health treatments. People are afraid of what they don't understand, and this fear can breed stigmatizing beliefs.

Not surprisingly, these experiences and beliefs create factors that inevitably become barriers to treatment for African American older adults with depression. All twenty older African American participants I interviewed had experienced moderate to severe depressive symptoms at some point but none were currently in mental health treatment for depression and only four said

they had ever been in mental health treatment. Those numbers are so small. And it is frustrating to know that you can help a group of people, but because they don't think they can be helped you know they are suffering through something that they just don't have to. The lack of engagement of African American older adults in mental health treatment is partially due to the powerful obstacles that deter them from help-seeking, despite perceived need and experiencing significant depressive symptoms. Participants identified a number of barriers to help seeking that seem to be directly influenced by their experiences of being older African Americans dealing with depression as a member of the black community. Some of the most prevalent barriers acknowledged were lack of faith in mental health treatment, lack of access to treatment, mistrust, ageism and of course stigma.

-KC

Memo: Cultural Coping Strategies

Date: April 17, 2008

Dear Kya,

I have been also thinking more about how participant experiences in the black community have impacted these cultural coping strategies that participants must engage in. Participant experiences dealing with depression as an African American and living in the black community negatively impacted their attitudes about seeking mental health treatment as well as their treatment seeking behaviors. These experiences and beliefs led to factors that inevitably became barriers to seeking mental health treatment for African American older adults with depression. Despite high levels of depressive symptoms very few people sought mental health treatment. So these older adults were dealing with significant mental health symptoms, but encountered a number of barriers in thinking about or attempting to access mental health treatment. So what do they do? They had to do something to keep from getting progressively worse. So if they experienced stigma when seeking treatment, had a lack of confidence in the effectiveness of mental health treatment and a lack of faith and mistrust in service providers, than what are the other options? They had to identify coping strategies that were effective and that were culturally acceptable. Strategies their family and friends would accept and not stigmatize them for. Strategies to coping with their depression that participants identified were handling depression on their own, pushing through the depression and letting go and letting God. This makes sense right? If you can't get treatment then you try to treat it yourself, when that doesn't work you just try to push through it and when all else fails if you don't have faith in mental health treatment you still have faith in God. –KC

Memo: Outcomes for African Americans With Depression

Date: April 19, 2008

Dear Kya,

So now I have to think about if depression in the black community, barriers to seeking mental health treatment and cultural coping strategies can lead to another something. An outcome variable. Negative outcomes for African Americans with depression. Dr. Rosen got me thinking about this. And I think there is a connection here that really ties this whole story together. Participants identified a number of experiences living with depression in the African American community and discussed how this has impacted their help-seeking behaviors. African American older adults had cultural beliefs around the value of keeping mental health concerns to yourself, and not talking to other individuals about mental illness. They were socialized to fear mental illness and seeking mental health treatment due to a concern of stigmatization and a lack of knowledge about effective mental health treatments and the importance of mental health in general. These experiences then led to a number of barriers to older adults access to professional mental health treatment, and in turn older adults had to identify other coping strategies to engage in that were culturally relevant and acceptable. While trying to push through depression and handling it on your own is noble, these methods are not likely to be effective. Especially if you are dealing with chronic and re-occurring depression. Faith in God and prayer is also an important aspect of healing. But handling depression on ones own and attempting to push through it despite severe symptoms may not be the most effective strategies in reducing the burden of mental illness.

Therefore, as a result of their experiences in the black community, the identified barriers to seeking mental health treatment and cultural coping strategies which may or may not be effective, there are a number of outcomes for African American older adults with depression that need to be addressed. These experiences, barriers and strategies produced a vulnerable group of African Americans older adults who have a difficult time recognizing when they are depressed, and when they do they choose to use different language to discuss it, or deny being depressed altogether rather than to try to find an effective method to treat it. This makes sense right? If you can't get treatment, and you can't treat it yourself or with the help of God then what do you do? Well, you deny having depression all together. If you can make yourself deny that you have depression, and have others believe I too, then you don't have to deal with it anymore. Interesting.

-KC

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