Qualitative Examination of African American Women's Perspectives about Depression

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Abstract

Gaining greater understanding about the various psychosocial, socio-cultural, and environmental factors that may influence experiences of depression among African American women (AAW) helps elucidate how this mental illness impacts the lives of this population. Sixty-three adult AAW comprised the study's convenience sample. Specifically, focus group cohorts inclusive of women from an academic institution, a primary healthcare clinic, and an urban community setting were conducted. Results indicated six (6) dominant common themes as issues that may increase risk for depression among diverse AAW. Similarities and differences about perspectives that contributed to depression were delineated among the three cohorts of AAW. These results are important for mental/behavioral health researchers, practitioners, and public health professionals that are engaged in the design and implementation of culturally centered and gender-specific prevention and intervention strategies targeted to AAW at risk for depression.

Keywords: *Diverse African American Women; depression; Focus Groups*

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I. Introduction

Mental illness has grown as an area of interest in public health concerns, especially among African Americans. Several health disparities already plague the African American community when compared to other ethnicities; mental illness and the lack of care only add to these disparities as it too affects access to and utilization of care and increased disability, which can affect one's overall socioeconomic status. The United States (U.S) Department of Health and Human Services, Office of Minority Health reports that African Americans, when compared to non-Hispanic Whites, are approximately 30% more likely to report having some form of mental illness (U.S. DHHS, 2001). African Americans are also less likely to receive proper diagnosis and treatment for mental illnesses and are more likely to experience poorer functioning and greater disability from untreated mental illnesses (Alegría et al., 2008).

Major depressive disorder (MDD) is one of the most prevalent mental health problems in the United States that is associated with considerable impairment in functioning, and it affects approximately 14.8 million adults annually with women 18 to 45 years of age accounting for the largest proportion of this group (NIMH, 2012). It is estimated that in the next 20 years, depression will be the leading cause of disability worldwide and in nations with high incomes, such as the United States (Gonzalez, Vega, Williams, Tarraf, West, &Neighbors, 2010). It is a disease that may be characterized as a pernicious psychiatric illness associated with episodes of long duration, high rates of chronicity, relapse and recurrence, psychosocial and physical impairment, and mortality and morbidity – with a 15% risk of death from suicide in patients with more severe forms of depression. Findings from the Summit on Women and Depression convened by the American Psychological Association suggest that examination of genetic factors, sex hormones, life stress and trauma, interpersonal relationships, and cognitive styles may provide greater insight into contributors to depression for women (Mazure, Keita, & Blehar, 2002). It is estimated that one woman in four is likely to suffer from a depressive episode at some time during her life (National Alliance on Mental Illness, 2012).

MDD presents a formidable burden in the African American community (Bailey, Patel, Barker, Ali, & Jabeen, 2011). There are several complex factors that lead to depressed moods in African Americans, and some of the challenges that may contribute to poor diagnosis and treatment among this population include low access to care, low socio-economic status, low educational attainment, low quality of treatment, and cultural barriers (US Department of Health and Human Services, 2001). Furthermore, African-Americans are less likely than whites to

report symptoms of major depressive disorder, and when they do, it tends to be more chronic and severe, and they are also much less likely to undergo mental health treatment (Williams, Gonzalez, Neighbors, et al, 2007). This may in part be due to stigma and less trust with the medical community, poor or no insurance coverage for mental health services, problems accessing culturally responsive mental health professionals, and over reliance on family, friends and/or religious communities for support (Holden & Xanthos, 2009). Also, cultural influences shape how people of different races deal with and/or cope with the depression (Williams, 2008).

There is a dearth of research concerning depression among diverse African American women (AAW), and it is under-recognized and under treated among this population of women (Levin, 2008). Furthermore, AAW are at increased risk for depression due to deleterious historical, socio-cultural, environmental and economic experiences (Brown, Schulberg, & Madonia, 1996). Depression among AAW may also present with multiple co-morbidities that include post-traumatic stress disorder, substance abuse disorders, and generalized anxiety disorder (Carrington, 2006). Thus, more empirical data is needed to better determine strategies for improving recognition/early detection of depression among AAW; particularly since AAW are not frequently confronted with isolated stressors, but with a constellation of multiple and complex issues that can engender anxiety and symptoms of depression (Taylor & Holden, 2009).

The purpose of this cross-sectional qualitative pilot study was to foster greater understanding about diverse AAW's perceptions about psychosocial, socio-cultural, and environmental related contributors to depression for AAW.

II. Methods

Research participants and recruitment sites

The research participants included a convenience sample of 63 adult AAW that delineated an interest in sharing their personal experiences and views about mental health issues, particularly concerning depression. Three cohorts of women were recruited from a comprehensive primary healthcare clinic, a small private academic institution, and an urban community setting.

Procedures

This study approved by the Morehouse School of Medicine Institutional Review Board and the Grady Hospital and Clinics Research Oversight Committee. Recruitment flyers were posted in various areas at each of the study sites. For the primary healthcare clinic recruitment site, eligible women were approached in waiting rooms. For the academic/professional recruitment site, a detailed email about the study was sent to potential research participants inviting them to participate in the study. For the community recruitment site, AAW that were in a local community center were approached for potential study participation.

Three mental health and wellness women's empowerment and educational sessions (approximately 1.5 hours each) were held for each of the three cohorts of AAW. In each session, research participants completed a demographic questionnaire, participated in a focus group (facilitated by a psychologist and master level research assistant), listened to an educational presentation about depression and AAW, and completed an evaluation survey. Each participant was provided with a $25.00 stipend and a local mental health and wellness community resource

guide.

Each of the six focus groups included 8-10 individuals. They were held in a local community room of a library and lasted for approximately 1 hour each. The focus group questions that were posed to the research participants centered on psychosocial, socio-cultural, and environmental related topics relative to their views about depression.

Data collection and analyses

Data from each focus group discussion were collected using digital voice recorders. Two digital recorders were used in each focus group in order to limit potential sound interruption within the session settings and increase the quality of the data retrieved. Additionally, written field notes were collected by two note takers during the focus group sessions. All data were compiled by two graduate-level research assistants with prior experience in qualitative data analysis.

Standard culling methods were used to review and code transcripts independently by each research assistant. Once independent review was complete, the research assistants compared notes and developed conclusions based on consistencies seen within the data. This method was used to generate dominant themes from the focus group discussions, in order to establish meaningful codes. These codes and themes were then analyzed to highlight connections, relationships, context, conditions, and consequences in the data (Strauss and Corbin, 1990).

Dominant themes were identified as the concepts that were repeated most frequently within the group(s) during the focus group sessions. The coded and dominant themes generated allowed for conclusions to be drawn regarding the research participant's perceptions and experiences; and facilitation of a final review of data outcomes by mental health researchers not affiliated with the study. All data was further reviewed by the principal investigator before final analysis was compiled.

Validity and trustworthiness

Risks to validity and trustworthiness within various paradigms of qualitative research are related to three primary areas, including: (1) subjectivity, (2) credibility and (3) interpretation. Threats concerning subjectivity may include the role of bias, threats associated with subjectivity can involve issues of sample size and triangulation, and threats relative to interpretation may involve issues of self-centeredness and isolation.

The study team sought to minimize threats to validity and trustworthiness by utilizing several approaches. Specifically, to address issues of subjectivity, the research team used multiple team members in the collection, review, and interpretation of field notes and the tape recorded focus group discussions. In addition, we incorporated informal participant feedback from focus group discussions regarding perspectives that were shared and themes emergent in the data as a check on bias. Based on the small sample size, some risks to the credibility and interpretation were inherent. Yet, triangulation through the use of examination of field notes, content and process memos, and collaboration with research team members/focus group facilitators somewhat reduced such risks. Further efforts to decrease bias and subjectivity were taken by use of a tertiary review of themes and data by other social and behavioral scientist colleagues who did not attend the focus group sessions. Feedback from these individuals provided additional valuable insight into interpretation of data and explanation of outcomes.

III. Results

DEMOGRAPHIC VARIABLE	Total		Professional		Clinic		Community	
	M	SD	M	SD	M	SD	M	SD
Age	44.73	12.04	45.88	10.97	45.65	13.44	41.40	11.66
	N	%	N	%	N	%	N	%
	63	100	25	39.7	23	36.5	15	23.8
Marital Status								
Single	20	35.7	5	20.8	9	47.4	6	50.0
Married	20	35.7	12	50.0	5	26.3	2	16.7
Divorced	15	26.8	7	29.2	4	21.1	4	33.3
Cohabitating	1	1.8	0	0	1	4.3	0	0
Number of Children								
Zero	13	24.1	4	19.0	7	35.0	2	16.7
One	14	25.9	8	38.1	4	20.0	1	8.3
Two	15	25.9	5	23.8	5	25.0	4	33.3
Three	9	16.7	3	14.3	3	15.0	3	25.0
Four or more	4	7.4	1	4.8	1	4.3	2	16.7
Employment Status								
Unemployed	16	26.7	1	4.2	10	45.5	5	38.5
Part-time	2	3.3	0	0	1	4.5	1	7.7
Full-time	30	50.0	22	91.7	3	13.6	4	30.8
Temporary	1	1.7	1	4.2	0	0	0	0
Retired	5	7.9	0	0	5	22.7	0	0
Disabled	2	3.3	0	0	1	4.5	1	7.7
Student	2	3.3	0	0	1	4.5	1	7.7
Homemaker	2	3.3	0	0	1	4.5	1	7.7
Highest Level of Education								
Some High School	3	4.8	0	0	1	4.3	2	15.4
High School	3	8.1	1	4.0	3	13.0	1	7.7
Technical or Vocational	7	11.3	1	4.0	4	17.4	2	15.4
Some College	27	43.5	9	36.0	12	52.2	6	46.2
College	13	21.0	8	32.0	3	13.0	1	7.7
Post Grad/Profession	7	11.3	6	24.0	0	0	1	7.7
Total Household Income								
Under $5000	14	23.3	1	4.2	10	47.6	3	21.4
$5,000-$9,999	2	3.3	0	0	1	4.8	1	7.1
$10,000-$14,999	6	10.0	0	0	3	14.3	3	21.4
$15,000-$24,999	5	8.3	1	4.2	3	14.3	1	7.1
$25,000-$34,999	7	11.7	4	16.7	2	9.5	1	7.1
$35,000-$49,999	12	20.0	6	25.0	2	9.5	4	28.6
$50,000-$74,999	6	10.0	5	20.8	0	0	0	0
$75,000-$99,999	5	8.3	5	20.8	0	0	0	0
$100,000-$149,999	2	3.3	1	4.2	0	0	1	7.1
$150,000-$199,999	0	0	0	0	0	0	0	0
$200,000-$249,999	1	1.6	1	4.2	0	0	0	0

Table 1: Participant demographics

Study Population and Demographics

The total study sample included 63 AAW from three distinct populations: professional (n=25, 39.7%), clinic (n = 23, 36.5%), and community (n = 15, 23.8%). All of the women identified their ethnicity as African American; and their ages ranged between 22 and 64, with a mean age of 45 years old (SD = 12.05). Specific demographic statistics highlight diversity between the three groups. For example, the majority of women in the professional group were married (50%) while the majority of women in the clinic (47.4%) and community groups (50%) were single. Additionally, the professional (80.9%) and clinic (80%) groups had 2 or less children while the community group had two or more (75%). Employment differences were expected with the majority of the professional group (91.7%) being employed full-time. The clinic group had 13.6% employed full-time, 45.5% unemployed, and 22.7% retired. The community group was nearly evenly dispersed between unemployed (38.5%) and employed full-time (30.8%). The clinic and community groups also included a few individuals who identified as being disabled, students, or homemakers. While the majority of women in all groups reported some college education, it was expected to find that the professional group also had high rates (56%) of having earned a college degree or higher. Income was expected to correlate with the employment status and the professional group was found to have a significantly higher income with 75% earning $35,000 or more. These results and additional demographic findings from the three sub-samples are shown in Table 1.

On the demographic/background questionnaire, two open-ended questions were posed:

(1) *What issues and/or concerns do you think contribute to AAW that experience depression*? The following categorical concepts were generated from women's responses:

- Lack of Control in Life
- Difficult Personal Relationships
- Multiple and Demanding Social Roles
- Chronic Stressors
- Poor Personal Well-being

(2) *What treatment strategies do you think may contribute to AAW to cope better with depression?* The following categorical responses were provided:

- Psychotherapy
- Counseling
- Support Groups
- Living a Healthy Lifestyle
- Spiritual Fellowship and Religious Worship
- Education About How to Deal with Stress and Life Problems

IV. Focus Group Findings

The majority of women in all of the focus groups noted that as AAW in the United States, they have complex multiple social roles, such as; parent; head of household; being a partner in an intimate relationship; and being an employee. Among these social roles, the women noted that it is common to lose oneself and have a "lack of regard for self" while trying to balance many responsibilities. Remarks by the women indicated that these roles may add to other social stressors such as poor personal relationships; discomfort with ethnicity/racial identity; poor self-concept; lack of resources to adequately take care of personal and family responsibilities; acceptance of physical and emotional abuse in personal relationships; constantly striving to be the "strong one" in the family that takes care of everyone; and a sense of being overwhelmed by life demands.

Dominant theme 1: ***ethnic differences in experiencing the symptoms of depression***

Within the three groups, the majority of women indicated that AAW experience depression in different ways from women of other ethnicities. Most notable were distinctions made between AAW and White women. Some views expressed suggested that AAW have more stressors and issues to deal with that may cause them to internalize their emotions and to not seek help for symptoms of depression, in part due to the belief that AAW should be able to "handle their problems on their own"; whereas the perception that some White women do not have as many problems to deal with and that they have more resources to deal with the depression than do AAW. For example, a woman in the clinic group stated:

> We get these [daily stressors] more often than other groups. It's easy sometimes for them [white women] to deal with everything.

In the professional group several women commented on the idea of the "strong black woman" saying that, in addition to stigma, many AAW do not admit they are depressed because they feel as if they cannot show a weakness or vulnerability because of the multiple, competing, and demanding roles (i.e., mother, wife, sister, girlfriend, niece, employee, community member, church member etc.) in which they must "juggle" and maintain in their lives. Furthermore, the women spoke about the perception that they see it as being "okay" for White women to be depressed and it is an accepted issue within the White community; but that it is not accepted in the same way in Black community. Regarding this issue, a woman in the clinic sample stated:

> I think as black women and the black race that one thing that we don't do is seek support.

Another woman stated:

> We don't seek the knowledge about mental health issues, especially depression.

Dominant theme 2: *cognitive style/ways of thinking*

The discussion of what depression means among the women in each group somewhat differed showing that the women had different ways of thinking about the disease. Among women from the clinic and community groups depression was indicated to be related to social and environmental factors. That is, the stress and strain that women experience is directly associated with coping with issues in their neighborhood and communities, including; violence; a lack of supportive community resources; and limited access to health and human services. Women in the professional group attributed depression more so to the individual person that experienced it. For example, a woman stated:

> It is a state of mind that a person may have and it kind of guides their conduct and the way they feel about themselves.

Dominant theme 3: *stigma about mental illness and depression*

The discussion of the significance of stigma about depression in the African American community was consistent across the three groups. Many women believed that stigma is a barrier to many African American's acknowledging and accepting that they may have mental health issues, such as depression. Among the professional sample, one woman stated:

> There's stigma attached [to depression]; there's no such stigma with them [people in the white community]. They [white women] can probably go out and get a job…it's a difference that's partly because of the society that we live in…I don't think it's necessarily always deliberate, but we're in America.

A woman in the clinic sample indicated:

> We need to put it [information about depression] in the media…it's not like only the white man can be depressed…they have support groups, and we don't.

A woman in the community sample stated:

> They [white people] come from a place where they have things, and we don't.

In general, there was a perception of racial differences and inequity for African Americans in general and AAW in particular concerning views of stigma related to depression.

Dominant theme 4: *strategies for coping with challenging life circumstances*

The discussion surrounding whether or not the women knew someone suffering from depression displayed some similarities and differences between the groups. Many of the women in the professional sample openly discussed family members who have been treated for depression, particularly through psychotherapy, counseling, or use of faith based support. Some women in the clinic sample indicated an aversion to the use of medication to help treat depression. For example, one woman indicated:

> I don't agree about the medication part. Its better if you can just talk to somebody…you have a lot of professionals who try to tell you what they think you should do.

In the community sample one woman stated:

> I think she's [her mother] is depressed. There's so many [black women] that's depressed and they don't want to acknowledge it…they don't want to deal with it.

In general, among all of the groups, the comments show the women's support of taking responsibility and taking some action to address depression if it is recognized. Taking ownership and responsibility to improve one's life and try to deal with one's depression was shown to be important to the women.

Major psychosocial, socio-cultural, environmental related issues and depression

The women were asked to discuss their perceptions of issues that may relate to experiences of depression among AAW. Major themes were extracted from the data for each cohort. While all major themes were not found in each group, five (5) themes consistently appeared in each cohort described below and indicated in Table 2.

Themes	Professional n=25	Clinic n=23	Community n=15
Psychosocial Factors			
Competition with Other Woman	X	-	-
Poor Self-Acceptance/Perception	X	-	-
Traumatic Life Experiences	X	X	X
Denial of Having Depression	-	-	X
Socio-cultural Factors			
Poor Spiritual and/or Religious Support	X	X	X
Racism	X	-	-
Family Problems/Discord	X	X	X
Personal Relationship Challenges	X	X	X
Societal Pressures to Succeed	X	-	-
Sexism	X	-	-
Lack of Education	-	X	X
Culturally Centered Issues that Support Stigma about Depression	X	X	X
Environmental Factors			
Financial/Economic Concerns	-	X	X
Employment Concerns	X	X	X
Problems with Childcare/Rearing	-	X	X
Environmental Problems (i.e. neighborhood violence, poor community resources etc.)	-	X	X

Table 2: Dominant focus group themes organized by group

Traumatic Life Experiences

Several women disclosed and/or alluded to an experience of trauma such as physical violence, mental and/or emotional pain resulting from a trauma induced situation, and victimization due to a crime as a major problem related to depressive symptoms and/or depression.

Poor spiritual and/or religious support

Many of the women suggested that the lack of a strong religious and/or spiritual basis contributed to AAW's inability to handle depressive symptoms and/or depression. It was suggested that a commitment to fellowship with other "like-minded" religious individuals could serve as a buffer against some of the problems that could evoke symptoms of depression, and serve as a positive way of coping with challenging life circumstances.

Family problems/discord

Issues that centered on poor communication, tenuous situations, difficult dynamics and poor interpersonal interactions surfaced as the primary concerns relative to family discord. It was suggested that any family centered problem alone or intermingled problems could elevate an AAW's risk for depressive symptoms and/or an episode of depression.

Personal relationship challenges

Relationship problems with husbands, boyfriends, and/or significant others concerning trust issues, commitment issues, parenting matters, handling of responsibilities, and "power struggles"[1] surfaced as the key areas of focus that may increase an AAW's propensity for depressive symptoms and depression. It was suggested that an immense amount of stress within personal relationships could negatively impact the mental and emotional stability of AAW.

Employment and financial concerns

It was suggested by many of the women that problems related to steady employment which contributed to financial concerns could lead to symptoms of depression for AAW. Chronic anxiety centered on un-employment and underemployment was a major issue for many women, some of which reported that they were the primary breadwinners and/or caretakers within their homes. The women indicated that economic/financial problems can significantly contribute to stress levels which may heighten vulnerability for depression. It was clear from many of the women's perspectives that a cyclical relationship exists between education, employment status, and stress; and that AAW may not have the same opportunities to receive education beyond high school and may also experience economic hardships (especially single mothers that head their households) more so than women from other ethnic groups. One woman stated:

> To be a poor Black woman is hard; it's easy to get down and out…depressed, when you don't have much.[2]

[1] Power struggles identified by participants included acceptance of gender roles within the home setting.

[2] Participant expressed this sentiment during one of the focus group sessions.

V. Discussion

The groups of AAW that participated in the study had diverse backgrounds which contributed to the rich information that was ascertained. By including women of diverse backgrounds greater breadth of knowledge about AAW's views, perceptions, and experiences relative to depression was established. The dominant themes delineated between the various focus groups indicated the difference in views of the women about issues relative to experiences of depression.

Psychosocial related factors

The women reported that for many white Americans it may be perceived as "OK" to seek help for mental health problems. This supports some research about the disparities that exist between blacks and whites for mental health help-seeking (Wrenn, Wingo, and Moore, 20011) such that African Americans are more reluctant than whites to seek specialized mental health care. Furthermore, stigma may contribute to an AAW to feel less motivated to seek mental health care and/or to have decreased self-efficacy in being able to adequately address her own mental health needs. Stigma about mental illness and depression is a pervasive and problematic issue in the African American community. Thus, it was no surprise that stigma was included as a dominant theme between all three groups. There is a clear indication of the need for a greater emphasis on community education about depression in the African American community, particularly concerning prevention, early recognition, treatment strategies, and coping mechanisms. According to the National Mental Health Association (2007) , approximately 63% of African Americans see depression as a "personal weakness"; 31% believe that depression is a "health" problem, and 30% state that they would "handle it" (depression) themselves if they were depression, while nearly 20% said that they would seek help for depression from family and friends.

Socio-cultural related factors

Current research suggests that resiliency and spirituality/religiosity are deeply rooted in African American culture (Mattis & Jagers, 2001) and these concepts were found in the present study, which may represent a salient experience for many AAW, regardless of their individual backgrounds and experiences. The six domains: spiritual/religious support, employment issues, stigma about depression, family relational challenges, personal relationship concerns, and personal trauma which were found to be common among the three groups as contributors to depression was not surprising., AAW as a group have historically been perceived as "strong", "spiritually grounded", and able to cope simultaneously with a myriad of difficult circumstances which engenders these constructs.

Findings also yielded important information about strategies for coping with depression that may be beneficial for AAW. Some women indicated the need for a comfortable, welcoming, and culturally-centered environment that promoted their empowerment would be ideal. There was an affinity for a model that included the integration of therapeutic and professional counseling, support groups, and educational materials about depression within a faith-based setting as a means to reach many AAW. Furthermore, a family centered approach to improving mental health and wellness that included significant others and children was also noted as a viable approach for strengthening and building healthier African American families. It should be noted that medications were not mentioned by any of the groups in the suggested treatment strategies. This supports research that suggests that for management of depression, many African Americans prefer counseling over medications, and are less likely to find

anti-depressant medications acceptable for treatment (Brody, Khaliq, & Thompson, 1997).

Environmental related factors

The environmental concerns addressed for the women highlight the perceived heavy financial burden that exists within the AAW community. The women highlight multiple stressors around finances. Employment and under employment are mentioned, but the role these women play in their family is also important. The head of household role that some women play contributes significantly to the stress identified by the women. This information shows that women who are financially responsible for their families may require a different technique in approaching depression treatment than other women. This also indicates that for women in African American community, there is a need to explore options for greater financial stability including education and job/employment opportunities.

Our findings have utility for the development of constructs to include in future research utilizing mixed methods (qualitative and quantitative), culturally-centered, and gender-specific methodology for prevention and intervention approaches for addressing relevant psychosocial, socio-cultural, and environmental for depression; and the promotion of mental health and wellness for diverse AAW. AAW are faced with many challenges throughout their lives relative to their historical, cultural, and social structural position in the United States. These issues in addition to individual, familial, and community responsibilities, heighten this population's vulnerability for depressive symptoms and depression. It is imperative that psychologists carefully examine mental and behavioral health conditions, especially depression, from holistic, multidimensional, and contextual perspectives. This will aid social and behavioral research scientist's ability to more appropriately discern the complexities associated with improving the psychological well-being of diverse AAW.

Study limitations

Limitations to the present study must be acknowledged. First, use of a relatively small convenience sample limits the external validity of the investigation. The selected groups of women represent only a small segment of AAW in a metro area. Future studies utilizing larger samples of AAW may shed greater insight into this area of research. Second, the qualitative research design yielded self-report data in a group format which may suggests that the possibility of inaccurate reporting and/or social desirability regarding responses that were given by research participants. Thus, although very rich data was generated, the findings are not generalizable.

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