

Barriers to treatment and culturally endorsed coping strategies among depressed African-American older adults

Kyaïen O. Conner^{a*}, Valire Carr Copeland^b, Nancy K. Grote^c, Daniel Rosen^b, Steve Albert^d, Michelle L. McMurray^a, Charles F. Reynolds^a, Charlotte Brown^a and Gary Koeske^b

^aDepartment of Psychiatry, School of Medicine, Western Psychiatric Institute and Clinic, University of Pittsburgh, Pittsburgh, PA 15213, USA; ^bSchool of Social Work, University of Pittsburgh, Pittsburgh, PA, USA; ^cDepartment of Psychiatry and School of Social Work, University of Washington, Seattle, WA, USA; ^dDepartment of Behavioral and Community Health Sciences, Graduate School of Public Health, University of Pittsburgh, Pittsburgh, PA, USA

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Objective: Older adults are particularly vulnerable to the effects of depression, however, they are less likely to seek and engage in mental health treatment. African-American older adults are even less likely than their White counterparts to seek and engage in mental health treatment. This qualitative study examined the experience of being depressed among African-American elders and their perceptions of barriers confronted when contemplating seeking mental health services. In addition, we examined how coping strategies are utilized by African-American elders who choose not to seek professional mental health services.

Method: A total of 37 interviews were conducted with African-American elders endorsing at least mild symptoms of depression. Interviews were audiotaped and subsequently transcribed. Content analysis was utilized to analyze the qualitative data.

Results: Thematic analysis of the interviews with African-American older adults is presented within three areas: (1) Beliefs about Depression Among Older African-Americans; (2) Barriers to Seeking Treatment for Older African-Americans; and (3) Cultural Coping Strategies for Depressed African-American Older Adults.

Conclusion: Older African-Americans in this study identified a number of experiences living in the Black community that impacted their treatment seeking attitudes and behaviors, which led to 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 toward mental health services.

Keywords: depression; beliefs/attitudes; health service use; stigma; aging

Introduction

Depression is a common psychiatric disorder, affecting approximately 9.9% of the US adult population in a given year (NIMH, 2003). Among the elderly (aged 65+), depression is a major public health concern leading to increased disability, morbidity, and risk of suicide (Blazer, 2002). Depression has been identified as the most prevalent psychiatric diagnosis among the elderly (Liebowitz et al., 1997). In 2004, approximately 17% of women and 11% of men aged 65 and older had clinically relevant depressive symptoms (Federal Interagency Forum, 2006). By 2030, the number of older adults with depression is expected to nearly double the current number (Jeste, Alexopolous, & Bartels, 1999) and the World Health Organization has projected that depression will be the leading cause of disability in all countries by 2020 (Murray & Lopez, 1996).

Older adults are particularly vulnerable to the effects of depression (Sirey, Bruce, & Alexopoulous, 2005). Although depression is more prevalent among younger adults, older adults with depression are less likely to be identified and treated. In particular,

African-American older adults with depression are less likely than their White counterparts to receive an appropriate diagnosis (Gallo, Cooper-Patrick, & Lesikar, 1998) or to receive empirically supported treatments for depression (Wang, Berglund, & Kessler, 2000; Young, Klap, & Sherbourne, 2001). 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 (Brown, 2003; DHHS, 2001; Outlaw, 1993; Williams, Neighbors, & Jackson, 2003); and they tend to have fewer psychological, social, and financial resources for coping with this stress than their White counterparts (Choi & Gonzales, 2005). Despite risk of psychiatric disorders due to these socio-cultural and environmental factors, prevalence rates of depression among African-American elders tend to be equal to or slightly less than their White counterparts (Blazer, Landerman, Hays, Simonsick, & Saunders, 1998; Gallo et al., 1998), while some studies suggest only slightly higher rates of depression (Blazer, Hughes, & George, 1997). However, African-American elders are significantly

*Corresponding author. Email: connerko@upmc.edu

less likely to seek mental health treatment (Conner et al., 2010); suggesting that they may be utilizing informal strategies to cope with their psychological distress and depressive symptoms.

Disparities in treatment engagement and retention

Disparities in treatment engagement and retention for depressed older adults from all racial backgrounds are discouraging. Of the 35 million people in the US over the age of 65, it is estimated that half are in need of mental health services, yet fewer than 20% actually receive treatment (Comer, 2004). In fact, older adults seek mental health treatment less than any other adult age group (Bartels et al., 2004). When given a choice between psychotherapy and pharmacotherapy, older adults tend to express a preference for psychotherapy (Gum, Arean, & Hunkeler, 2006). However, when older adults receive a referral to psychotherapy for mental health treatment, they are not likely to follow up and make an appointment (Watts et al., 2002), suggesting that there are significant barriers deterring older adults from initiating and engaging in even their preferred method of mental health treatment.

Similar disparities are found for African-Americans and African-American elders in particular. African-Americans seek treatment at half the rate of their White counterparts (Brown & Palenchar, 2004; DHHS, 1999). 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). Though there is less research available on the mental health service utilization patterns of older African-Americans, research suggests that depressed African-American elders are less likely than their White counterparts to be currently in treatment, to intend to seek treatment in the future, or to have ever sought mental health treatment for depression (Conner et al., 2010).

Barriers to treatment engagement and retention

Research has identified a number of barriers to treatment engagement for African-American older adults with depression. In conducting focus groups with geriatric mental health clinicians to identify the most salient barriers to mental health treatment for their African-American and Latino older adult clients, researchers identified ageism; shame and stigma; cultural and language barriers; fear and distrust of the treatment system; lack of information; and lack of insurance and transportation as barriers to treatment utilization (Choi & Gonzales, 2005). Negative attitudes about mental health treatment has also been identified as a strong barrier to treatment engagement (Conner, Koeske, & Brown, *in press-a*; Conner et al., *in press-b*). In a representative sample of 250 depressed older

adults, African-American elders had more negative attitudes toward seeking mental health treatment than their White counterparts; further these negative attitudes were strongly and negatively correlated with service utilization (Conner et al., 2010).

While a number of studies have been conducted to examine barriers to treatment among older adults, there is a dearth of qualitative studies that have examined the experience of depression among African-American elders and their perceptions of barriers faced when seeking mental health services. In addition, there is little research examining how coping strategies are utilized by African-American elders who choose not to seek professional mental health services. Having an understanding of specific barriers to mental health service utilization, in addition to culturally endorsed coping strategies, will aid researchers and clinicians in developing culturally relevant clinical interventions as well as treatment engagement and retention strategies to meet the needs of this growing population. In this study, we conducted semi-structured in-person interviews with African-American older adults who had at least mild symptoms of depression to examine: (1) their experience with depression; (2) their process of determining whether or not to seek professional mental health treatment for their depression; (3) any barriers they experienced when attempting to seek professional mental health treatment; and (4) culturally sanctioned strategies they engaged in to cope with their depressive symptoms.

Method

Research design

Study participants were recruited by the University Center for Social and Urban Research (UCSUR) at the University of Pittsburgh using random digit dialing (RDD) telephone sampling methodology. This approach was utilized to identify a representative sample of a total of 449 depressed adult respondents (aged 18 and older) living in Allegheny County, Pennsylvania who were willing to participate in a survey interview over the phone to attain information about their perceptions of, and experiences with, depression and of seeking mental health treatment (Brown et al., 2010). Of the 449 adults surveyed, 248 were older adults (Conner et al., 2010). Eligible study respondents for this subsample of older adults included men and women aged 60 years and older who: (a) were English speaking; and (b) reported at least mild-to-moderate symptoms of depression (a score of 5 or above) according to the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001). Exclusion criteria included: (1) mood symptoms within the normal range; (2) bipolar depression; and (3) current substance abuse/dependence within the past six months.

Out of the total surveyed sample of 248 older adults, 120 were older African-Americans. Of the 120

older African-Americans who completed the initial telephone survey, 84 agreed to be contacted in the future to potentially participate in an in-depth semi-structured interview. In preparation for the interviews, we utilized a random numbers chart (Rubin & Babbie, 2005) to select 50 African-American older adults to be contacted. When potential 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. Potential participants were informed that we were conducting interviews with older African-Americans to attain a deeper understanding of their experiences with depression and barriers to care. Out of the 50 older African-Americans contacted, 37 consented to participating in the interviews (Figure 1). Interviews took place in participants' homes, and all lasted between 30 and 90 min. Interviews were conducted by the study principal investigator and a trained masters level licensed social worker. All participants received \$30 for their time.

Data collection

Before beginning the qualitative interviews, participants completed a demographic questionnaire and completed the PHQ-9 (Table 1). 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 semi-structured interviews, even if their PHQ-9 scores had decreased over time. The semi-structured interviews contained questions about (1) respondents' experiences with depression and treatment seeking; (2) barriers to seeking care; and (3) strategies for coping with their depression. The interviews were digitally audiotaped and subsequently transcribed verbatim. Contact procedures were approved by the University of Pittsburgh's Institutional Review Board (IRB) and informed consent was obtained for each subject in accordance with university policies.

Procedure and qualitative data analysis

Through rigorous and systematic reading and coding of the transcripts, and the process of content analysis (Berg, 1995; Patton, 1990), salient themes emerged through the data. To begin the process of content analysis, transcripts were first *in vivo* (line-by-line) coded utilizing respondents' own language and meanings to represent their statements (Glaser, 1978; Strauss & Corbin, 1990). Each transcript was read and coded by the first author. Sections of the transcripts were read and coded by the first author as well as by the coinvestigators to enhance the study's reliability. Weekly memos written by the first author were shared with study coinvestigators to receive critical feedback during the process of analysis.

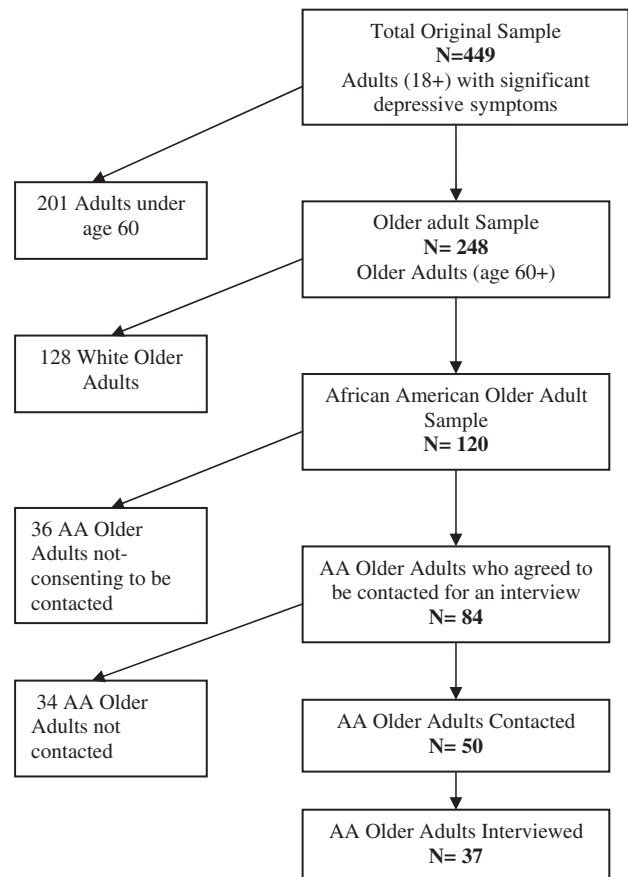


Figure 1. Sample flowchart.

Table 1. Sample demographics for qualitative interviews.

Characteristics ($N = 37$)	N (%)
Gender	
Female	31 (84)
Male	6 (16)
Age	
60–70	14 (38)
71–80	14 (38)
81+	9 (24)
Education	
Grade school	8 (22)
High school	21 (57)
College	7 (19)
Graduate school	1 (2)
Marital status	
Widowed	28 (75)
Married	4 (11)
Divorced/single	5 (14)
Patient Health Questionnaire score	
2–9 (mild)	18 (48)
10–14 (moderate)	10 (27)
15–19 (moderately severe)	6 (16)
20–27 (severe)	3 (9)

Memos were utilized to stimulate analytic insight and to tie pieces of data together (Maxwell, 1996). The next phase of the content analysis process was the development of categories, which were then conceptualized into broader themes that fit under the three topic

categories we wanted to address in this study (i.e., experiences with depression, barriers to seeking treatment, and coping strategies). This process involved objectively analyzing the contextual information that emerged from the codes, and subsequently identifying and categorizing the main themes and patterns found in the data (Berg, 1995; Patton, 1990). At 37 interviews, there was saturation of data in that the interviews no longer yielded new information. Therefore, the researcher concluded this study with a total of 37 interviews.

Results

Thematic analysis of the 37 interviews with African-American older adults within our three major topic areas yielded a number of interesting themes and sub-themes in relation to (1) Beliefs About Depression Among Older African-Americans; (2) Barriers to Seeking Mental Health Treatment; and (3) Culturally Endorsed Coping Strategies for African-American Older Adults with Depression. These themes are discussed in detail in the following sections (Table 2), and statements made by interview participants that reflect the themes are reported. To protect anonymity, pseudonyms are utilized to represent study participants.

Beliefs about depression among older African-Americans

The older adults in this study discussed very powerful experiences growing up as African-Americans and living in the Black community, and how those experiences shaped their identity, including their attitudes and beliefs about mental health. Questions asked during the qualitative interview included questions about their personal experience with depression: (1) What does being depressed mean to you?; (2) Were you worried to tell anyone that you were depressed?; and (3) Have you had negative experiences in your community due to your feeling depressed? We also asked some questions about their perceptions of depression among African-Americans in general (e.g., Is depression generally accepted in the African-American community?).

Cultural beliefs

Most participants acknowledged that the Black community is not largely tolerant of individuals suffering from depression, or any other mental health problem. Participants attributed intolerance to the socialization received in Black families about mental health problems and how to handle them in a culturally appropriate manner. Participants endorsed the belief that African-Americans should not talk openly about

their mental health problems. They believed that an individual experiencing depressive symptoms should keep this information to oneself.

'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' (Ms M, an 85-year-old woman).

Participants felt that the tendency to keep mental health concerns within the family is part of the African-American culture and the way that most Black folks were raised. When asked why she did not 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' (Ms Y, a 94-year-old woman).

Fear

Participants expressed a sense of fear in the Black community about the repercussions of having a mental illness and of seeking treatment. 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.

A lot of them [African-Americans] are afraid that it will be on their record, like for life, and it would destroy them . . . 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 [depression] 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. (Ms L, a 73-year-old woman).

Multiple stigmas

Participants discussed 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 a mental illness. When asked if depression was generally accepted in the Black community, Ms R, an 85-year-old woman, stated: 'I think they [Black community] would be less accepting.' Ms D, a 70-year-old woman stated: 'Depression is less accepted in the Black community. Because people just don't have the patience . . . you know. They say, "You crazy," and forget ya.'

Table 2. Identified themes and sub-themes.

Theme	Sub-themes	Definition
(1) Beliefs about depression among older African-Americans	(1.1) Cultural beliefs	The way in which being an AA impacts participant experiences of being depressed and stigmatized
	(1.2) Fear	Participant believes that if something is wrong, you keep it inside
	(1.3) Multiple stigma	Participant fears the outcomes of seeking mental health treatment
	(1.4) Lack of information	Participant perceives that there is greater stigma associated with being an AA and depression
(2) Barriers to Seeking Treatment		Participant believes that there is a lack of information in the AA community about mental health
		Factors have become obstacles to seeking mental health treatment for participants
	(2.1) Experiences of stigma	Participant experiences or perceives stereotypes, prejudice, and discrimination
	(2.2) Lack of faith in treatment	Participant lacks confidence in mental health providers
	(2.3) Lack of access to treatment	Participant has difficulty accessing mental health treatment
	(2.4) Mistrust	Participant lacks trust in the mental health care system
(3) Cultural coping strategies	(2.5) Ageism	Participant experiences prejudice and stereotyping based upon old age
	(2.6) Lack of recognition	Participant has difficulty recognizing that he or she is depressed
		Culturally endorsed strategies to deal with their depression
	(3.1) Self-reliance strategies	Participant believes that he/she should be able to handle being depressed without seeking treatment
	(3.2) Frontin'	Participant's decision to depressive symptoms from family and friends
	(3.3) Denial	Participant experiences denying that he or she is depressed
	(3.4) Language	Participant uses less stigmatizing terminology to express emotional well-being to oneself and others
(3.5) Let Go and Let God	Participant believes that prayer and a relationship with God is the first line of defense in the treatment	

Note: AA, African-American.

Lack of information

Participants often stated that the African-American community is less informed about depression, mental health, and mental health treatments than other communities. Participants believed that this absence 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, Mr J, a 65-year-old man stated: 'I didn't even know there was a treatment. I didn't know you could get treated for depression. I thought if you had it, depression, they just go out and kill themselves... I didn't know you could get help.'

Other participants agreed that the lack of information and education negatively impacts African-Americans' decisions about seeking mental health treatment. Participants felt that oftentimes African-Americans simply do not want treatment. When asked why she thought African-Americans sought mental health treatment at much lower rates than White

Americans, one participant stated: 'Because Black people don't want treatment. I think because they not educated about it, you know how important it is... 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' (Ms Y, a 94-year-old woman).

Barriers to seeking treatment

Participants' experiences dealing with depression as an African-American and living in a predominantly low-income African-American community seemed to have an impact on their treatment seeking. Not surprisingly, these experiences and beliefs created factors that inevitably became barriers to treatment for African-American older adults with depression. Out of the 37 African-Americans interviewed, all 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 6 reported

they had ever been in mental health treatment. The lack of engagement in mental health treatment was partially due to the powerful obstacles that deterred them from help seeking, despite perceived need and experiencing significant depressive symptoms.

Some of the most prevalent barriers acknowledged were lack of faith in mental health treatment, lack of access to treatment, mistrust, ageism, lack of recognition, and stigma. Questions asked during the qualitative interview to gain insight into barriers to seeking treatment included: (1) 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; (2) What were barriers to getting help for your depression; and (3) Has stigma affected your decisions about whether or not to seek treatment.

Experiences of stigma

In this study sample, experiences of stigma were prevalent among African-American older adults with depression and were identified by a number of participants as a barrier to seeking mental health treatment. Out of the 37 participants interviewed, 35 believed that people negatively stereotype individuals with depression and 32 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 their children. That, they're completely...they're crazy...When a person's depressed, they're crazy' (Ms E, a 67 year-old woman).

Ms A, a 72-year-old woman, discussed similar stereotypes about people with depression. She stated that people with depression are often described as being: 'Crazy, listless, lifeless, and opinionated.' One participant stated that he experienced being stereotyped when he was going through a depression:

'Think they ain't trustworthy, 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... They think you're going to harm them or something like that or... Dangerous or something like that' (Mr W, a 75 year-old man).

The experience of being an African-American older adult with depression impacted experiences with stigma. Of the 37 participants, 35 believed that stereotypes about depression were more severe if you were also a person of color. For example, Ms J, a 67-year-old woman stated: 'Oh, you know, they down on "em cause they Black." It depends on the color. It differs yeah for White from Black. [If you're Black and depressed] you're worthless, you know.' In addition to identifying stereotypes about individuals suffering from depression, participants also discussed experiences with public stigma, or experiences of prejudice,

being stereotyped or discriminated against due to their mental health status. They discussed situations where they witnessed the stigmatization of depressed persons in their community. In these situations, individuals with depression were not only stereotyped, they were also treated unfairly 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. Many participants talked about their own experiences of being stigmatized due to being depressed. Ms D, a 70-year-old woman, stated that when she was depressed, the people around her treated her differently. When asked what her family's reaction was 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.'

Participants related their experiences of public stigma to their decisions to keep their mental health status to themselves. Participants were worried about the reactions they would get from people if they found out about their depression. Ms V, a 68-year-old woman stated 'I didn't tell my family because they'll say things like "Oh, she ain't depressed, she's crazy. Pay her no mind, she don't know what she's talking about"... They figure, oh you better get away from her. You don't know what kind of medication she taking.'

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 felt that many people in their community go through hard times, so if they are depressed and cannot get through their sadness, then they must not be very strong. Mr B, a 70-year-old man stated that he believed having depression made him weak, and that he blamed himself for his depression: 'I think [of depression] as a weakness. I want to just beat myself up and cuss myself out and everything like that, you know. I just down rate myself.'

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. Mr W, a 75-year-old man, stated: 'Nobody mentions the word psychiatrist. You know. First thing they think about is something wrong with your mind.' Mr G, an 82-year-old man stated: 'Why would anybody say that they're going to see the shrink? 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.'

Lack of confidence and mistrust in mental health treatment

Many participants expressed a lack of confidence 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 help. This caused many participants to lose faith in the ability of the health care system to treat individuals suffering from mental health problems. For example:

'Nowadays, like people with mental illness... they don't seem to get help. 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' (Ms D, a 70-year-old woman).

Participants also expressed a lack of confidence in mental health treatments and mental health care providers. 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... And they're treating one thing and it's another. They're treating depression, and it's not even depression, it's something else.' (Ms S, an 82 year-old woman).

Participants expressed concern about the methods that mental health professionals have for treating depression. These concerns often led to mistrust of mental health professionals. Many participants were against taking antidepressant medications, and believed that mental health care providers would attempt to persuade them to take a pill to relieve their symptoms. Ms A, 72 years old, stated: 'Don't give me no medicine that's going to make me sicker than I am... and doctors are famous for that... I don't care who you are, they're not God, they're doctors.'

Some participants endorsed mistrust stemming from negative previous experiences with the mental health system, usually with 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. Ms T, an 80-year-old woman stated: '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. You can tell if you can trust them' (Ms G, a 68 year-old woman).

Lack of access to mental health treatment

In addition to a lack of confidence 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 also have physical health limitations. In addition to transportation, 23 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. Ms J, a 67-year-old woman stated: 'I think a lot of them [African-Americans] don't want to ask for help cause you don't want to be... rejected. I think that plays a big part in it 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... hinders them from seeking help. They don't have the right insurance, because I went through that... and you feel like, well, no use of you going cause they ain't gonna look at me cause I ain't got [insurance]... you feel rejected, you know.'

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 might benefit more from them. When asked why he had not sought mental health treatment for his depression, Mr B, a 70-year-old male stated: 'Age, I mean... you ain't got much longer to live.' Ms Y, a 94-year-old woman held similar beliefs. When asked the same question she stated: '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. Ms T, an 80-year-old woman talked about feeling old and stated that sometimes she thinks: 'Hey, I'm 80 years old and what am I here for?' 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. Mr W, a 75-year-old man 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 [depressed].'

Lack of recognition

Some participants felt that it was hard to recognize that they were actually depressed, which became a barrier to their service utilization. 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. Ms N, a 73-year-old woman stated: '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.' Mr W, a 75-year-old man stated: 'You don't know when you're depressed.'

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. Ms S, an 82-year-old woman stated: '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 it made us more resilient, like if we have depression, we can bounce back easier than White people.' These beliefs can often lead to difficulty recognizing a need for professional mental health treatment. Ms N, a 73-year-old woman stated: 'They're sad; they don't know they're mentally ill, they have no idea. They have no idea how sick they are.'

Cultural coping strategies

In this sample study, despite current 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 identify coping strategies that were effective and that were culturally acceptable; strategies that other individuals in their social network would accept and not stigmatize. Participants identified a number of strategies to cope with their depression. The most common strategies included handling

depression on their own, pushing through the depression, frontin', denial, 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.

Self-reliance strategies

Self-reliance was a common strategy identified by study participants for coping with depression. If participants recognized they were depressed and needed to do something to feel better, seeking professional mental health treatment was often not an option for them. Seeking professional mental health treatment was frequently viewed as a last resort, and participants tried numerous strategies to manage depression on their own. This often included things such as keeping busy, staying active in the community, cooking and cleaning, and unfortunately self-medicating with alcohol and nicotine. Mr W, a 75-year-old 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.' Other participants expressed similar beliefs. Ms L, a 73-year-old 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 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. Mr G, an 82-year-old man stated: 'It is 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.'

When asked why she chose not to seek mental health treatment for her depression, Ms N, a 73-year-old 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 strength in me' (Ms Y, a 94-year-old woman).

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; ride it out until it just goes away on its own. 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 do not view depression as a medical condition, it is likely that they will also believe that you should just be able to get over it. Ms N, a 73-year-old woman stated that when it comes to African-Americans and depression: 'Us people never think we're mentally ill, let's put it that way. It was always, 'Oh... there's nothing wrong with you.' Ms J, a 67-year-old woman expressed a similar sentiment: '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... things you just learn to deal with.'

This perception of other'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. Ms L, a 73-year-old woman, stated: 'I think that they think you should just push through it.' Ms E, a 67-year-old 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:

'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.' (Ms D, a 70 year-old woman).

Frontin'

Participants talked a lot about frontin' or hiding one's mental health status as a way to cope with their depression. The word frontin' came directly from the statements of participants. Frontin' is a word used to capture behaviors engaged in by study participants to hide their depressive symptoms from other people. 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' (Ms N, a 73 year-old 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. When asked if she talked to her family or friends about being depressed, Ms A, a 72-year-old woman stated: 'I don't do that, I keep it to myself.' Ms J, a 67-year-old woman expressed a similar sentiment. When asked the same question, she responded by stating: 'No, because I always showed, you know, I'm trying to be bubbly, 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' (Mr G, an 82-year-old man).

Denial

Some participants went beyond frontin' about their depression to lying to others and denying their depression to even themselves. Participants felt that African-Americans often coped by believing what they were going through was not related to mental illness. 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. Ms L, a 73-year-old 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 PHQ-9 that made them eligible to participate in this study. When asked how she handled talking to her family about her depression, one participant stated:

'Not admitting it, don't admit it. And...I'd say denying, denying that [you are depressed]...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]' (Ms N, a 73-year-old 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. Ms M, a 85-year-old woman stated: '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.'

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. Ms Y, a 94-year-old 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' (Ms E, an 82 year-old 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. When asked why they did not seek mental health treatment, a majority responded by talking about their relationship with God and their belief that the Bible and prayer would heal them. Ms M, an 85-year-old woman stated: 'Just let go and let God.' 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' (Ms E, an 82-year-old woman).

When participants lacked faith in professional mental health treatment, they maintained their faith in God. When asked about potential treatments for depression, Ms Y, a 94-year-old woman responded: 'I want to pray about it. I want to talk to God about it and his Holy Spirit will guide you. 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:

'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' (Mr G, an 82-year-old man).

Discussion

African-American older adults with depression in this study have experienced a lifetime of discrimination, racism, and prejudice, and they lived in communities

where they learned to survive despite these oppressive circumstances. These experiences impacted study participants' attitudes about mental illness and seeking mental health treatment. African-American older adults endorsed cultural beliefs that valued keeping mental health status private and not talking to others about mental health concerns. African-American older adults in this 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 they believed existed 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 of being an African-American older adult with depression led to a number of barriers to seeking mental health treatment. Participants identified experiencing both internalized and public stigma, which is consistent with research suggesting that African-Americans are more concerned about mental illness stigma (Cooper-Patrick et al., 1997), are more likely to experience internalized stigma about mental illness (Conner et al., 2010) and live in communities that may be more stigmatizing toward mental illness (Silva-de-Crane & Spielberger, 1981). Participants in this study identified a number of stereotypes associated with being depressed (e.g., crazy, violent, and untrustworthy) which are generally associated with more severe and persistent mental illnesses like schizophrenia and psychosis. It seemed that the label of having a 'mental illness' regardless of the type, positioned individuals into this stereotyped and stigmatized category. This is consistent with other research suggesting that older adults of color tend to view any mental health problem as being on the level of psychosis with little flexibility in the definition (Choi & Gonzales, 2005). This suggests that more accurate information about mental illness and the differences between having depression and psychosis may need to be targeted toward racial minority elders.

Participants endorsed a lack of confidence in treatment and had mistrust for mental health service providers. Interview participants' lack of trust in mental health service providers negatively impacted their 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 often 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 as 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; F. Terrell & S. Terrell, 1984). Participants also felt that they were too old for treatment to be effective for them. 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 one of the most significant barriers to accessing mental health treatment for older adults. Finally, participants often had difficulty recognizing their depression and felt that as African-Americans, they were supposed to live with stress and that they did not need professional mental health treatment. While participants were able to identify symptoms of depression (e.g., sad/depressed mood, lack of interest), they often combated these feelings with self-reliance strategies and pushed themselves through. Older African-Americans in this study engaged in a number of culturally endorsed strategies to deal with their depression including handling depression on their own, trying to push through it, frontin', denial, using non-stigmatizing language to discuss their symptoms, and turning their treatment over to God.

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. In some instances, 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 this study had greater public and internalized stigma, which led to their reluctance to be surveyed. Therefore, the African-Americans who participated in this study may have had less stigma and more positive attitudes about mental illness and seeking mental health treatment than the eligible population. The cross-sectional nature of the study limits the ability to determine changes in treatment seeking attitudes and behaviors over time. The small sample and limited geographic region where we recruited study participants impacts the generalizability of the study findings. Additionally, all information received was by self-report, and with an older adult sample, this creates potential recall bias issues.

Conclusion

Older African-Americans in this 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 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 at reducing their depressive symptoms.

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. Clinicians must be knowledgeable about the differences in language expression utilized by African-American elders to discuss their depressive symptoms. It is likely that one of the reasons depressed African-American elders are less likely to receive an appropriate diagnosis is due to their use of non-stigmatizing language to reflect their symptoms, which may make assessment and diagnosis more difficult with this population (Gallo et al., 1998). 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, Houston, Van Voorhees, Ford, & Cooper, 2007; Thompson et al., 2004). Providers can use this as a way to develop a therapeutic relationship and enhance level of trust.

This study also suggests that 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 older adult clients, and allow their treatment to be influenced by spirituality (Givens, Kalz, Bellamy, & Holmes, 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. These strategies can aid practitioners in targeting and mitigating the impact of barriers to engaging in mental health treatment among this population.

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