

Reconceptualizing Access: A Cultural Competence Approach to Improving the Mental Health of African American Women

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SUMMARY. Despite the prevalence of mental illness among African American women, only a limited number of them seek or accept help from mental health service delivery systems. An extensive review of the literature revealed that (1) racism and discrimination, (2) socioeconomic

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status, (3) stress and well being, and (4) housing and neighborhood conditions must be considered in an assessment of the mental health status of African American women. These factors negatively affect their mental health and should be addressed in eliminating disparities in access to and utilization of mental health services. We recommend a process by which mental health providers reconceptualize access to mental health services using a socio-cultural framework. The knowledge gained in this process will result in increased provider cultural competence. This developmental process would be facilitated by the use of a socio-cultural conceptual model for treatment engagement. The model takes into consideration the barriers to mental health treatment services that, in part, have to be eliminated by mental health providers in order to decrease disparities and enhance both access to and utilization of mental health services by African American women.

KEYWORDS. Cultural competency, mental health, African American women, health disparities, socio-cultural

INTRODUCTION

Despite considerable progress in the overall health of U.S. citizenry, racial and ethnic minority populations experience continuing disparities in the burden of mental illness (Hines-Martin, Malone, Kim, & Brown-Piper, 2003). According to the Surgeon General's Report (U.S. Department of Health and Human Services [USDHHS], 1999), the prevalence of mental illness is higher among African Americans than in the general population. For mood disorders such as depression and anxiety, African Americans have higher prevalence rates than Whites (Fabrega et al., 1994; Neighbors et al., 1999). Given their social, cultural, and economic status in the United States, African Americans are at higher risk for mental illness. They are more likely to be exposed to mental disorders, less likely to seek treatment, more likely to use hospital emergency rooms when seeking treatment, and more likely than Whites to receive inpatient care (Brown & Palenchar, 2004; USDHHS, 1999).

Epidemiological research on mental illness suggests that African Americans are more likely than Whites to report simple phobias, suffer from panic and sleep disorders, and present more co-morbidity among anxiety-related forms of illness (Snowden, 1999). Although the incidence of depressive disorders is higher among African Americans com-

pared to Whites, African Americans are less likely to be diagnosed with the depressive disorders and more likely to be diagnosed with schizophrenia (Morse, Johnson, & Heyliger, 2000; Neighbors & Williams, 2001; Neighbors, Trierweiler, Ford, & Muroff, 2003).

Researchers (Brown, Shear, Schulberg, & Madonia, 1999; Heurtin-Roberts, Snowden, & Miller, 1997; Myers et al., 2002; Snowden, 1999) suggest that certain mental illnesses manifest themselves differently in African Americans than among Whites. For example, African Americans with anxiety disorders may exhibit more somatic disorders and complaints. Depression in African American women continues to be misdiagnosed because of mistrust of mental health professionals; high levels of institutionalization (i.e., in-patient treatment); cultural barriers; reliance on family, friends, and the religious community for support; symptoms that are inaccurately assessed because of the way in which they manifest themselves in African American women; and socioeconomic factors including limited access to appropriate treatment (Klonoff, Landrien, & Ullman, 1999). To obtain a more accurate assessment or diagnosis, African American women should have complete medical histories taken and a physical examination to help determine the actual cause of their presenting symptoms.

The Surgeon General's Report on culture, race, and ethnicity identifies access to care as a major factor in mental health disparities (USDHHS, 2001). The report identifies a number of barriers to mental health services for African Americans, which include having no health insurance or being underinsured, disjointed services, location of culturally specific services, stigma, and cultural insensitivity exhibited by mental health providers (Hines-Martin, Malone, Kim, & Brown-Piper, 2003; USDHHS, 1999). The contributors to these barriers are connected to the social and economic determinants of mental health status—stress, poverty, racism, and discrimination—for many African American women (Chadiha & Brown, 2002; Lincoln-Smith, 1998; Klonoff, Landrine, & Ullman, 1999; Kwate, Valdimarsdottir, Guevarra, & Bovbjerg, 2003). The prolonged negative impact of racism and discrimination, poverty, substandard housing, neighborhood conditions, lack of health insurance, difficulty obtaining healthcare, and fewer choices with which to receive care have all been linked to poor mental health status among African American women (Chadha & Brown, 2002; Klonoff, Landrine, & Ullman, 1999; USDHHS, 2001).

AN ECOLOGICAL SYSTEMS MODEL FOR ENHANCING ACCESS TO MENTAL HEALTH SERVICES

In order to decrease the existing racial disparities in the utilization of mental health services by increasing access to care, we recommend developing a culturally competent approach to engaging African American women in treatment services. This approach can be facilitated by using a socio-cultural model to develop accessible mental health service systems, and to provide training that is sensitive to the needs of African American women. This behavioral model of access to health services use was originally developed in the 1960s by Andersen (1995). It was designed to (1) facilitate understanding why families use health services, (2) define and measure equitable access, and, (3) assist in developing policies to promote equitable access to medical care. Although the model has been revised several times over the past four decades (Andersen, 1995), the overall framework is consistent with existing knowledge of barriers to access and utilization of mental health services.

In this article, we propose a modified version of the Andersen model as one strategy for increasing access to mental health services by African American women. This socio-cultural model represents an ecological systems perspective, which is inherent in the third phase of the original model's evolution (Andersen, 1995). The socio-cultural model we propose was developed from existing empirical literature that examined access to and utilization of mental health treatment services by African American women and the factors contributing to the mental health status of these women (Brown, Abe-Kim, & Barrio, 2003; Chadiha & Brown, 2002; Copeland, 2005; Dana, 2002; Fisher & Shaw, 1999; Hines-Martin, Brown-Piper, Kim, & Malone 2003). The objective of the model is to provide practical recommendations for conceptualizing and interpreting socio-cultural factors for (1) developing engagement strategies to increase access to and utilization of mental health services, (2) addressing differences in mental health treatment services in the areas of health beliefs and health behaviors, and (3) promoting the development of a cultural and racial identity perspective for mental health service providers who work with African American women.

The model suggests that there are barriers to mental health treatment services that must be eliminated by providers in order to decrease disparities, enhance access to and utilization of mental health services, and improve the quality of care provided to this population (USDHHS, 1999; USDHHS, 2001). The model not only promotes facilitating access to and utilization of services by African American women, but it also

clarifies processes and approaches for organizations and policies that are aimed at designing culturally effective services for African American women. Further, the model provides a useful framework for interventions at multiple levels of the help-seeking process. At all levels, it acknowledges and incorporates the importance of culture, the assessment of cross-cultural relations, vigilance toward dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet the culturally unique needs of African American women.

A culturally competent system is developed through an awareness of the integration and interaction of culturally based health beliefs and behaviors, a culturally sensitive mental health system, and improved treatment outcomes for female African American mental health consumers (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Brach & Fraser, 2000; Hines-Martin, Brown-Piper, Kim, & Malone 2003). Providing culturally competent services has the potential to increase access to and utilization of mental health services, enhance engagement skills, improve health outcomes, increase the efficiency and competency of clinical and support staff, and result in greater client satisfaction with services within target populations (Anderson et al., 2003).

AFRICAN AMERICAN WOMEN AND MENTAL HEALTH

African American women are less likely than White women to use mental health care services despite equal or greater need (Brown, Abe-Kim, & Barrio, 2003; Caldwell, 1996; Kohn & Hudson, 2002). Sixty percent of African American women suffer from depression; however, few seek professional help due to stigma and the lack of providers who specialize in African American mental health issues (Curphey, 2004). In addition, these women are often misdiagnosed or go undiagnosed. Statistics regarding the prevalence of depression among African American women are uncertain due to the scarcity of empirical research investigations conducted with this population. African American women are reluctant to participate in research studies because of distrust and uncertainty about how the results will be interpreted or used (Davis & Ford, 2004). Despite research that validates the relationship between poverty and poor mental health, there are few studies that examine factors that could improve the mental health status of African American women.

Given their social position in the United States, African American women have been described as having “triple jeopardy status” (Bobo, 2001). That is, they are poor, experience single motherhood at higher

rates, and suffer from the stressful experiences of racial discrimination in both their professional and personal lives (Fischer & Shaw, 1999; Klonoff, Landrine, & Ullman, 1999; Warren, 1995). Further, this triple jeopardy status negatively affects their health and well being and the quality of life they experience. Because they are often heads of their households, many African American women with children are at higher risk for anxiety, depression, and other health problems (Bobo, 2001). A single parent who is trying to fulfill the roles of both parents may experience considerable stress as a result (Brooks-Gunn & Duncan, 1997; Cauce et al., 2002) African American women are also typically socialized to be caretakers, which may create conflict and psychological distress as they struggle with the concerns of raising a family. Having multiple roles and social identities, including being multigenerational caregivers, makes them more susceptible to poor mental health status and mental illness (Chadiha & Brown, 2002; Jackson & Mustillo, 2001).

One of the most common and costly of the mental illnesses is depression, and the functional disability associated with this condition is comparable to or worse than many chronic medical conditions such as arthritis, diabetes, and hypertension (Brown & Palenchar, 2004). For African American women, there are multiple risk factors for depression, including:

- reproductive issues
- personality styles
- sexual and physical abuse
- marriage and children
- stress
- income
- quality of family and work relationships
- perceived racial and gender discrimination
- environmental living conditions
- low self esteem
- decreased self-efficacy (Brown & Keith, 2003; Culbertson, 1997; Jackson & Mustillo, 2001)

The lower use of mental health treatment services by African American women is attributable to high cost and lack of insurance coverage, a resistance to inequitable treatment services, stigma associated with obtaining mental health services, attending a clinic dominated by White therapists and clients, perceived racial discrimination, cultural beliefs, and faulty expectations of treatment intervention and outcomes (Davis & Ford, 2004). Many African American women assume that their

therapists, who are usually White, will not understand the impact of race, gender, and economic distinctiveness in their lives. Further, the women are not sure if White therapists will be comfortable exploring issues that society uses to define African Americans and their social status (Copeland, 2005; Copeland, Scholle, & Binko, 2003). Most therapists, regardless of their own race or ethnicity, are trained in academic institutions that are a part of our dominant culture. Consciously or unconsciously, clinical scholars have played an active role in reinforcing racial and ethnic stereotypes within their traditional perspective of mental illness, rather than mitigating them. Formal training in majority institutions alone does not ensure the sensitivity and skills needed for developing culturally competent mental health service systems (Greene, 1996; USHHS, 1999).

SOCIO-CULTURAL FACTORS AFFECTING AFRICAN AMERICAN WOMEN'S MENTAL HEALTH

Current literature identifies the effects of culture and society on African American women's mental health and mental illness and on mental health services that are more responsive to their culture and social contexts (Hines-Martin et al., 2003; USDHHS, 2001). The socio-cultural factors that can negatively affect the mental health status of African American women include housing, neighborhood conditions, economic status, role strain, racism and discrimination, self-esteem, social networks and social supports, subjective well being, and stress (Hines-Martin et al., 2003; USDHHS, 2001). As Jackson and Mustillo (2000, p. 33) state, "African American women face multilayered realities that can compromise their ability to handle the stresses of everyday life." Throughout our literature review, four indicators emerged as dominant in the mental health status of African American women:

- housing and neighborhood conditions
- economic status
- racism and discrimination
- stress and well being

Housing and Neighborhood Conditions

The neighborhood environment and housing conditions in which African American women reside can affect their mental health. African American

women who live in areas with high rates of poverty and poorer neighborhood conditions are at an increased risk for poor mental health outcomes (Cutrona, Russell, Hessling, Brown, & Murry 2000; Jackson & Mustillo, 2001; Leventhal & Brooks-Gunn, 2003). African American women who live in more advantaged neighborhoods report significantly less physical and social disorder as well as significantly higher neighborhood satisfaction and an external environment with higher quality (Leventhal & Brooks-Gunn, 2003). In addition, African American women who live in Section 8 Housing within neighborhoods that have significantly higher incomes with fewer poor residents report having significantly fewer mental health disorders. This suggests that these women are less likely to report symptoms of distress, and their children are less likely to report anxious and depressive problems (Leventhal & Brooks-Gunn, 2003).

Cutrona and colleagues (2000) found the relationship between neighborhood economic disadvantage and depressive symptoms was mediated by neighborhood social disorder. Specifically, economic disadvantage affects depression through its association with social disorder. The Cutrona study was based on Social Disorganization Theory—the mechanism through which the ecological environment of poor neighborhoods affects a person’s mental health is beyond the influence of personal and family resources. Thus, the focus is on the relationship between neighborhood structure, social control, and crime. Accordingly, Sampson and Groves (1989) state that chronic socioeconomic disadvantage contributes to the destabilization of family and social ties within a community, undermining its ability to socialize and integrate its members into a system of shared norms, behaviors, and associations.

Social disorganization and economic breakdown are threats to individual mental health. Theoretically, there are three routes that lead to negative mental health outcomes: rules, resources, and routines. *Rules*—when people do not know each other in a community, they do not serve as agents of social control for each other. *Resources*—lack of resources (e.g., knowledge of available social services) results from the absence of bonds between individuals in the community. *Routines*—neighborhoods with threats to safety, poor quality housing, undesirable operations (e.g., liquor stores, adult book stores, etc.) impose high levels of daily strain on residents. The dynamics of neighborhood ties, social control, mutual trust, institutional resources, disorder, and routine activity patterns in low-income communities adversely affects mental health (Cutrona et al., 2000).

Poor neighborhoods have fewer resources and suffer considerably from distress, high unemployment and underemployment rates, homelessness, substance abuse and crime. These neighborhoods also tend to have high turnover rates of residents and low levels of supervision of teenagers creating an environment prone to violence. Exposure to violence leaves immediate and long-term effects on mental health. People who are poor are more likely to be exposed to stressful physical environments that have less social and material resources (USDHHS, 2001).

Socioeconomic Status

Several research studies (e.g., Alder, Boyce, Chesney, Cohen, Folkman, Kahan, & Syme, 1994; Chadiha & Brown, 2002; Lincoln-Smith, 1998; Moore et al., 2000; USDHHS, 2001) have reported that low-income adults have more mental health problems than their wealthy, economically advantaged counterparts. Poverty has been consistently identified as a powerful risk factor for depressive disorders and experiencing poverty as a woman has been referred to as a “pathway to depression” (Kohn & Hudson, 2002). African American women are at an even greater risk for depression because of their gender and poverty level. Depression and hostility have been shown to have a consistent relationship with socioeconomic status and the development of certain physical health outcomes such as coronary heart disease (Alder et al., 1994). Socioeconomic status has been shown to be inversely related to major depression and depressive symptoms; higher socioeconomic status tends to reduce levels of stress and negative emotions (Alder et al., 1994).

In studies conducted by Chadiha and Brown (2002) and Lincoln-Smith (1998), a positive correlation between lower socioeconomic and poor mental health status in African American women was noted. African American women were more likely to be employed in jobs with high levels of work-related stress (tense work environments and demoralizing work) and salary inequity. Brown and Keith (2003) found that African American women who have never been married, who are heads of households, and who are employed in jobs with high levels of stress and low pay tend to experience higher rates of poverty and economic instability. The percentage of African American women who marry is declining. As a result, they are placed in a social position that increases their risk for developing negative mental health status and that can affect their access to mental health treatment (Bobo, 2001). A failure to

trust mental health providers and lack of insurance can further exacerbate existing mental health barriers (USDHHS, 2001).

Racism and Discrimination

A lifetime of confronting racism and discrimination by African Americans adversely affects their physical and mental health and increases their vulnerability for mental health disorders (USDHHS, 2001). Racial discrimination plays a role in the symptoms of psychiatric distress among the entire African American population (Klondoff, Landrine, & Ullman, 1999). In a study of African Americans' mental health and their perceptions of racial discrimination, Fischer and Shaw (1999) found that persons reporting lower preparation by their families for experiencing racist incidents showed a significant relationship between racist events and poor mental health outcomes. African Americans who reported low levels of racial socialization experiences and perceptions of more racial discrimination had higher levels of mental health problems than those African Americans who were socialized to "expect" experiencing racial discrimination throughout their lifetime. When self-esteem was used as a moderating effect, African Americans with higher levels of self-esteem and perceptions of more racial discrimination had higher overall mental health functioning.

Being an African American woman is associated with having greater stress and greater racial discrimination and predicted higher amounts of psychiatric symptoms (Klondoff, Landrine & Ullman, 1999). In addition, African American women who experience racism over the course of their lifetimes rate their overall health status as being poorer than others (Kwate et al., 2003). This finding was directly related to having a lifetime history of disease, indicating that racist experiences may lead to decreased immune functioning.

Racism in the workplace is a significant predictor of African American women's psychological well being. It is not simply another work stressor; racism adds to the strain of African American women's daily lives. Racism was found to negatively affect life satisfaction where non-racial work stress did not. It is suggested that African American women who experience racism at work may continue to feel satisfied with work; however, they may experience decreased satisfaction with life (Kwate et al., 2003).

Women who perceived greater financial need experienced larger decreases in life satisfaction than women who experienced less need. This

identifies financial stress as a moderating factor of racism that affects African American women's well being (Kwate et al., 2003).

Racism creates separate barriers to mental health treatment. African American women are denied equal access to quality mental health treatment based solely on their race. This is institutional racism. Racial barriers to quality treatment include lack of economic access to healthcare, barriers to healthcare treatment facilities and hospitals, limited mental health therapists with unbiased treatment interventions, discriminatory policies and practices, and lack of cultural competence (Collins, Hughes, Doty, Ives, Edwards, & Tenney, 2002; Snowden, 2003).

Stress and Well Being

Keith and Riley (2001) examined the association between work conditions and the mental well being of African American women. Findings from this research indicate that having control over work is an important job condition that is essential to healthy psychological functioning. Autonomy, a dimension of control, was frequently associated with lower levels of psychological distress. Most African American women have jobs that offer very little autonomy and result in less satisfied lives. When comparing homemakers to those employed outside the home, time and physical demands influenced the psychological well being of homemakers while time pressure and high demand jobs with little control influenced the psychological well being of employed women. Recognition of the quality of work was lower among homemakers than those employed. However, being appreciated shapes feelings of self-worth and affected the psychological well being of all of the women studied.

When Keith and Riley (2001) examined the differences in the stress and well being of married and unmarried African American women, the unmarried women who were homemakers were more likely to be less educated and less distressed than married women. Age was positively associated with distress and number of children was negatively associated with distress. The homemakers' symptoms of distress were less than those who were employed because they experienced more autonomy and control, fewer physical demands, and higher levels of appreciation and time pressures. For married women, high levels of education were associated with reduced levels of stress. Homemakers were more distressed than employed married women when controlling for physical demands and appreciation. Autonomy was associated with higher levels of distress for employed married women.

The four socio-cultural factors reported here can individually and collectively affect the mental health status of African American women. These factors should be considered when building a collaborative approach to treatment by the therapist and client (Office of Behavioral and Social Science Research, 2004; Warren, 1995). We suggest a more participatory decision-making approach on the part of therapists. This approach can be defined as increased help seeker (i.e., African American women) engagement in mental healthcare through information sharing, negotiation, and consensus seeking, which has been shown to be positively associated with satisfaction with services, successful self-management, adherence, decision-making, and symptom recovery among clients (van Ryn & Fu, 2003). This approach can ultimately lead to eliminating disparities in access to and utilization of mental health services by African American women (USDHHS, 200; van Ryn & Fu, 2003).

The dynamic interplay between social demographic factors, the physical environment, the multiple roles African American women play, economic status, and racial discrimination are all related to mental health status. The multiple realities that exist for many African American females can compromise their ability to handle the stress of everyday living, an initial risk factor for mental illness (Chadiha & Brown, 2002; Fischer & Shaw, 1999; Jackson & Mustillo, 2001; Klonoff, Landrine, & Ullman, 1999; Kwate, Valdimarsdottir, Guevarra, & Bovbjerg, 2003; Lincoln-Smith, 1998). Mental health treatment services should incorporate these socio-cultural factors because they address the psychological well being of African American women and are rooted in the ecological environment of these women. The socio-cultural context illuminates the everyday stressors that impact the social, political, and economic perspectives that affect psychological development as well as the ethnic and cultural influences that can facilitate access to mental health services.

A SOCIO-CULTURAL MODEL FOR ACCESSING MENTAL HEALTH SERVICES

We propose a socio-cultural model for understanding African American women's access to mental health treatment. The model takes into consideration the four socio-cultural factors (housing and neighborhood conditions, economic status, racism and discrimination, stress and well being), which are reflective of the population, as well as other characteristics:

income and status, social support networks, education, employment and working conditions, social environments, personal health practice and social skills, biology and genetics, and gender and culture (Whaley, 2001). Prior to reviewing the population's characteristics and the health-care system's external environment, the structural barriers to treatment and non-structural barriers at the community level, programmatic level, and individual level must also be addressed (Andersen, 1995; Klonoff, Landrien, & Ullman, 1999).

When engaging African American women in the therapeutic process, their cultural backgrounds, health beliefs, values, and informal support systems must be assessed and their experience with discrimination and socioeconomic differences must also be explored (Klonoff, Landrien, & Ullman, 1999). Both the interpersonal and intrapersonal dynamics that contribute to the mental health status of African American women must be understood for therapeutic engagement. This understanding should be communicated to these women by the mental health providers who should strive to portray themselves as genuine, honest, trustworthy, empathetic, and non-judgmental. The interconnectedness of attitudes, perceptions of mental health, mental illness, and treatment services can be barriers to service utilization and effective mental health treatment when they are not addressed (Copeland, 2005; Davis & Ford, 2004).

Mental health providers are often ambivalent about the factual and historical causes of differences in access, treatment, and outcomes and want to credit the lack of access to and utilization of mental health treatment services to the target population of African American women. This victim-blaming rationalization reinforces existing stereotypes and reinforces discrimination (Bobo, 2001). Both socioeconomic and racial differences can increase social distance, creating a vicious cycle. These differences can be part of a hidden agenda when majority providers lack the cultural competency skills needed to work with African American women. Prior to creating a culturally competent behavioral model for accessing mental health treatment for African American women, society's beliefs, stereotypes, prejudices, institutional racism, and overt racist practices must be considered as part of the problem.

Many models of intervention used in mental health treatment represent the majority population because the empirical studies, which result in evidenced-based treatment interventions, have been conducted with majority populations. Ethnocentric models of treatment, as well as the policies and procedures within the mental health care system, both private and public are designed, developed, planned and implemented by, for the most part, by White staff/administrators and providers. The existing

mental health services system is not culturally sensitive to the needs of African American women (Davis & Ford, 2004; Fellin, 1996; USDDHS, 2001). The extent to which conscious and unconscious bias permeates both the macro- and micro-structure of our mental health system are contributing factors to the racial disparities in mental health (Ryan & Fu, 2003; Snowden, 2003).

Developing Cultural Competency by Using a Socio-Cultural Model

Simply being culturally sensitive and culturally appropriate are inadequate when trying to capture the complex dynamics involved in providing mental health interventions to African American women. Cross and colleagues (1989) have proposed a useful conceptual framework that captures this dynamic and complex process. They define cultural competency as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations. The word ‘culture’ is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively” (Cross et al., 1989, p. 13).

Cultural competence involves the mental health provider’s cultural awareness, cultural knowledge, and cultural encounters. Cultural competency challenges the providers to extend themselves beyond sensitivity and awareness of cultural differences to concrete action steps for change in the implementation of therapeutic services (McPhatter, 1997). Increasing cultural competency skills is important for mental health providers for several reasons, including responding to current and projected demographic changes in the United States; eliminating long-standing disparities in the health status of people from diverse racial, ethnic, and cultural backgrounds; and, improving quality of services provided and outcomes. Becoming culturally competent is a developmental process; it evolves over time as providers simultaneously engage both knowledge and skill development (Sue, 1989).

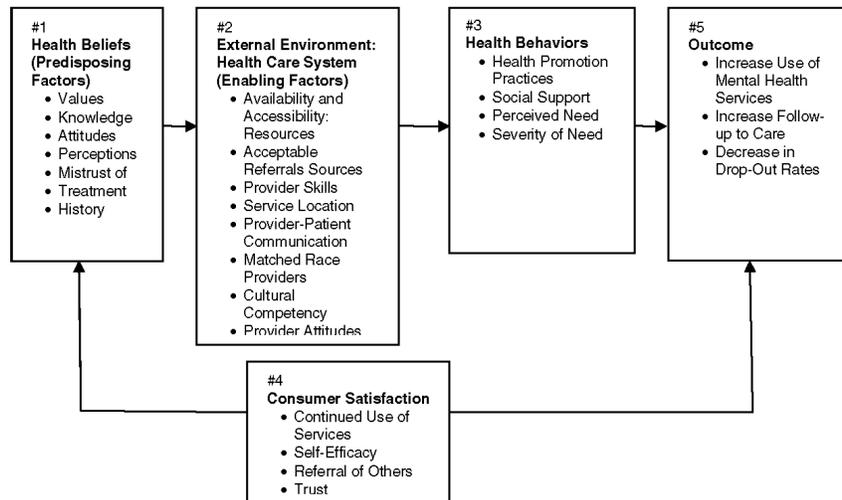
An assessment of African American women’s cultural background will help providers understand the attitudes (e.g., stigma, shame, fear) these women have towards a mental health diagnosis, which when discussed, provides an opportunity for therapeutic engagement. When appropriate, misinformation about a diagnosis can be countered with factual information. Providing African American women with feedback

and educational information about their symptoms will allow them to recognize changes in their behavior. Educational information on appropriate medications for their diagnosis, if necessary, is also appropriate to discuss during the development of the therapeutic relationship. Encouraging African American women to participate in therapeutic discussions with their treatment providers can enhance their coping skills (Warren, 1995) and build a collaborative, decision-making approach to treatment (van Ryn & Fu, 2003).

The proposed Socio-Cultural Model of Mental Health Access (Figure 1) focuses on the mechanisms through which African American women obtain mental health services. The model suggests that access to and use of mental health services by African American women is a function of their predisposition to use services, factors that enable or impede use, and their perceived need for mental health treatment (Andersen, 1995; Caldwell, 1996; Mays, Caldwell, & Jackson, 1996). Use of this model by mental health providers can be a first step towards developing the knowledge and skills required to become culturally competent. The components of the model are: (1) Health Beliefs, (2) Health Care System, (3) Health Behaviors, and (4) Consumer Satisfaction.

The first component of the model is health beliefs. These are the attitudes, values, and knowledge African American women have about

FIGURE 1. A Socio-Cultural Model of Mental Health Access



mental illness and mental health treatment that can influence their subsequent perceptions of need (including perceived mental health status) and use of the mental health services (Andersen, 1995; McKenzie & Smeltzer, 1997). Health beliefs provide one means of explaining how social structure might influence enabling resources, perceived need, and subsequent use (Andersen, 1995). Demographic factors (e.g., gender, race, socioeconomic and marital status) also suggest the likelihood that African American women will obtain mental health services.

Component #2 includes the external environment (physical, political, social, and economic) of the healthcare organizations and systems as well as personal enabling characteristics that are necessary for understanding the utilization of mental health treatment services. First, mental health providers and organizations must be geographically accessible to where African American women live and work. African American women need to be aware of available services, how to reach them, and how to utilize them based on their individual needs. Income, health insurance, a regular source of childcare, travel, and waiting times are some of the measures that must be considered.

The third component of the model provides an explanation of the health behaviors involved in accessing mental health treatment. These include any personal mental health practices (e.g., religion, prayer, spirituality, trust, social support networks). African Americans often rely on informal sources of healthcare advice as a help-seeking strategy, such as family members and social support networks (Jackson, Chatters, & Taylor, 1993; Neighbors & Jackson, 1996). According to Caldwell (1996), family, friends, neighbors, coworkers, and church members often provide needed informal support to assuage the stress of everyday living. There is an interpersonal and interdependent relationship between the helpers and help seekers. Furthermore, the use of professional services can be facilitated or hindered depending on the informal helper contacted within the social network system. These relationships are sometimes described as having a community gate-keeping function when individuals and groups are caught between the utilization of informal support systems and the use of formalized systems of care.

The degree of satisfaction African American women have with particular mental health services/organizations (component #4) can have a direct impact on the outcome—the further use of mental health services, follow-up to care, and decreased drop-out rates by themselves and by other African American women in their community (component #5). Similarly, dissatisfaction with these same services can feed into the predisposing factors (e.g., beliefs) of component #1. If an African American

woman is disappointed with the services received, this will affect her future use of these services. In addition, this dissatisfaction can affect the referral of others to these services.

The extent to which individual consumers of diverse backgrounds are satisfied with outpatient mental health services is crucial to ensuring broad access to care and reducing disparities in service utilization. Consumer satisfaction is an important measure of the quality of mental health services and is crucial in the evaluation of services received. It is viewed as an important sentinel of potential problems in healthcare delivery and is linked to healthcare seeking, treatment compliance, health status outcome, and changes in doctors' or health plans (Carr-Hill, 1992; Hall & Dornan, 1988; Litt, 1998; Marshall, Hays, Sherbourne, & Wells, 1993; Strasser, Aharony, & Greenberger, 1993). Measures of consumer satisfaction address a variety of domains that include perceived quality of care provided, perceptions of the overall care experience, outcomes of care, and interpersonal factors with regard to the way care is provided. Patient satisfaction ratings also include perceived characteristics of the healthcare encounter in relation to anticipated standards of care (Copeland & Scholle, 2000; Copeland, Koeske, & Greeno, 2004), the patient's orientation to care versus the actual conditions of care provided, and the interpersonal communication of office staff and provider with patients. We believe that for many African American women, consumer satisfaction is linked to both access and outcome. In our Socio-Cultural Model, consumer satisfaction functions as a feedback mechanism. Given the reliance on social support networks and informal sources of healthcare advice among African American women, consumer satisfaction can determine whether providers are recommended to others and if a client will return for treatment (Copeland, Koeske, & Greeno, 2004).

In contrast to the documentation that exists on racial differences in mental health status and services utilization, the number of studies focusing on African American women and healthcare satisfaction is quite small, and the results of the studies that do exist are inconsistent. Nonetheless, patient satisfaction has been found to be related to continuity in the provider/patient relationship, and a strong relationship between patient satisfaction and practitioner communication about mental health procedures has also been documented (Weiss & Ramsey, 1989).

According to Lillie-Blanton and colleagues (1996), the character of the social encounter between a provider and client is a determining factor in the receipt of health services. The process by which treatment is provided, in contrast to the way African American women think it

should be provided, is more important than the services themselves (Lillie-Blanton et al., 1966). As a group who has historically experienced alienation from the healthcare system, African American women may be sensitive to social encounters that are not genuinely “user-friendly.” Therefore, their ability to build trust in their therapeutic relationship and subsequently experience satisfaction with treatment received will be related to their continued use of services. Clearly, there is a need for a more comprehensive understanding of the mental health service perceptions and experiences of African American women.

DISCUSSION

African American women are reluctant to obtain mental health treatment services because there is a disconnect between what they need, what they perceive they need, and what mental health treatment service systems offer them. The current system is not sensitive to the unique needs of African Americans in general and African American women in particular. African American women avoid mental health treatment services because of (1) mistrust of the mental health providers; (2) fear of receiving a misdiagnosis; (3) lack of culturally competent providers who understand some of the major issues (race, class, gender, and culture) that define their lives; and (4) having reached their threshold for receiving inadequate mental health care.

African American women believe they are treated disrespectfully and are judged unfairly due to their race, ethnicity, and culture. In some cases, when African American women enter treatment, they are often viewed as members of a racial category rather than as individuals seeking mental health services. These women’s psychological health status cannot be separated from their race, gender, cultural values, and beliefs. Mental health professionals who are culturally competent will respect and understand their values and beliefs as a necessary means to successfully intervene and treat these women.

Cultural competence requires knowledge, skills, and valuing the differences African American women bring to the therapeutic process. While cultural training and awareness is helpful, practitioners must be aware of their own biases prior to interacting with and treating African American women. Cultural competence will require, when needed, acknowledging and validating that race and gender do matter and that at times both can result in unfair treatment. Cultural competence is not developed in

one workshop, one day of training, or even one month of training; is it developed over time.

African American women who perceive a system and its staff as welcoming, knowledgeable, and respectable and can facilitate change in their often chaotic lives will become satisfied consumers. The advantage of being a satisfied consumer may culminate in additional referrals to the agency, organization, or to a specific provider. However, if African American women are not satisfied with the mental health services received, they are more likely to tell others about their encounter, why they are dissatisfied, why they are not returning, and why they think other African Americans should not “go there” to receive services.

Consumer satisfaction is an important consideration and increases access and continuity of care. Informal support systems are very important to African American women in dealing with personal problems regardless of their magnitude. Many African American women are involved in social support networks. These women can be the gatekeepers and stakeholders who will encourage or discourage professional help seeking. This may be due to the feelings and attitudes African American women have toward the mental health system and providers they have experienced. From a cultural perspective, African Americans, and especially African American women, often rely on informal networks more than formal networks in dealing with daily stressors and disappointments. These informal networks allow the women to feel understood, respected, treated with genuine interest and concern, and have their strengths acknowledged and validated. These social networks can facilitate access to mental health providers whom the individuals in these networks feel can meet their mental health needs and provide culturally competent treatment.

Mental health treatment services for African American women require a sense of race consciousness and cultural competence, which must be reflected in the mission statement, policies, and treatment services of mental health agencies that genuinely want to provide mental health treatment to a unique population. This requires that mental health providers be educated and trained to provide culturally competent treatment services. Mental health providers should reflect on the client's cultural background, language, and gender and promote a greater appreciation for their racial identity and cultural values and beliefs. Finally, it is critically important for mental health professionals to demonstrate genuine empathy when working with African American women.

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