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African American Women and Their Experiences with Behavioral Health: Implications for Rehabilitation

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AFRICAN AMERICAN WOMEN AND THEIR EXPERIENCES WITH BEHAVIORAL
HEALTH: IMPLICATION FOR REHABILITATION

by

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B.A., Southern Illinois University, 2015

A Research Paper
Submitted in Partial Fulfillment of the Requirements for the
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A Research Paper Submitted in Partial
Fulfillment of the Requirements
for the Degree of
Master of Science
in the field of Rehabilitation Counseling.

Approved by:

Dr. Thomas D. Upton, Chair

Graduate School
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CHAPTER I

INTRODUCTION

Throughout this paper, several texts and articles will be explored and extensively analyzed to reveal that African American women who have experiences with behavioral health differ in comparison to other racial and ethnic groups in the United States of America. This study will reveal factors that affect other racial and ethnic groups when experiencing behavioral health, while simultaneously demonstrating how African American women have varying experiences in both their response and approach to behavioral health. Both of these factors [i.e. response and approach], regardless of social class, medical health and history, or education, affect the experience that African American women endure. As a result, information will be disseminated from a wide range of articles to reveal the different experiences that African American women in the American population have with behavioral health that is not common to other racial and ethnic groups. This is relatively important considering that much of the prior research is based on White women when concerned with anxiety and depression, which are grouped within the spectrum of behavioral health. However, this paper will focus on African American women's experiences with behavioral health and what this means for approaching and initiating services to combat the mental health concerns of depression and anxiety.

Background of the Problem

When exploring the concept of behavioral health, it is important to understand that behavioral and mental health are often used interchangeably. While the latter was understood as the functioning state of a person at a satisfactory level of emotional and behavioral adjustment (Princeton University, 2010), behavioral health insinuated that the [psychological] state of a person could be changed through behavior, or will. In fact, behavioral health is a fairly new

concept, unlike its predecessor, commonly referred to as mental health. Dating as far back as 5000 B.C.E with the evidence of “trephined skulls”[a surgical procedure where a hole was drilled in a living person], mental health had been witnessed and recorded throughout history before behavioral health emerged. The surgical procedure of “trephining” a skull was intended to help treat and combat health problems that were associated with intracranial diseases, epileptic seizures, migraines, and mental disorders (Irving, 2013). Through this process, the difference of trephining a skull would assert to mental health, whereas behavioral health would have addressed possible ways that the person may have improved their health problems (epileptic seizures, migraines, mental disorders, etc.) through diet, or some sort of action. Instead, trephined skulls became historical evidence of societies that first addressed and became aware of mental health before behavioral health was introduced as an alternative approach. Therefore, by nature, these definitions of behavioral and mental health essentially provide a context where information is conceptualized to merge both facets of *adjustment* and *changed behavior*, together.

In using the terms “depression” and “anxiety”, previous research has indicated that behavioral health has become a relatively huge health concern (Saraceno et al., 2007; Seligman & Csikszentmihalyi, 2014), due to a spike in suicides rates with the presumption that behavioral health is a risk factor (Tavernise, 2015; Balázs et al., 2013; Allan et al., 2015). The rise in the health concern has been especially prevalent within the female population of African Americans, whom are rated as a “high risk” ethnic group, insinuating that this subgroup of women are susceptible to suicide (Ramos, Carlson, and McNutt, 2004). While working to understand the ramifications that behavioral health consists of, many persons are becoming more aware of its deadly consequences if not properly addressed. Therefore, recognizing that suicide is the third leading cause of death for African Americans between the ages of 15 and 24, and subsequently

the seventh leading cause in the age group of 25 and 44 (Anderson et al., 1997 as cited in Kaslow et al., 2000), it is imperative to note how this information is comparative to gender. Adding that women are statistically three times more likely to attempt a suicide as compared to men (Kaslow et al., 2000), Black females are now more likely to be affected and become victims of suicide attempts (Zhwnkum et al., 2016). As a result, when related to race and gender, suicide affects African American women more likely than their counterparts, which would lend to heightened attention that addresses the risks for suicide among this cohort.

In 2010, the Census Bureau estimated that about 13.6% of the total population of the United States is composed of persons identifying as Black or African American, both alone and in combination with another ethnic group (Rastogi, Johnson, and Drewery, 2011). This would lend to the idea that compared to the vast majority of the American population, African Americans are identified as the part of the minority of the total and therefore, would have been expected to have parallel statistics. Yet, African Americans have been disproportionately *over*represented in statistics that identify barriers that pose as a hindrance to receiving health services. With approximately 321,654,000 total women residing in the U.S., roughly 14.5% of that total [population] represents African American women (ProQuest Statistical Abstract of the United States, 2017) and expected to continue to increase over the years. As rates of all minorities increase and projections continue to demonstrate a gradual trend that will continue over the coming years (Morello, C., & Mellnik, T., 2012), rehabilitation therapists and professionals are subjected to become very familiar with the best ways of highlighting inclusivity, as well as how to address the importance of utilizing resources and services.

In considering factors that affect women of color when stigmatized in behavioral health, economics and the likelihood of experiencing depression increase (Versey & Curtin, 2016). In

the United States, it has been recognized that approximately 13.7% of the U.S. population lives in poverty, with women and ethnic minorities being overrepresented (Lamison-White, 1997 as cited in Frank, Matza, & Chung, 2005). This results in over 50% of African-American women living in poverty in comparison to 25% of White women. Furthermore, research supports the notion that there is a difference in high and low rates of depression and anxiety amongst Blacks and Whites, with Black females being a higher risk (Watson, Roberts, and Saunders, 2011) than White females. Therefore, when considering the demographic characteristics that were identified by Frank, Matza, & Chung (2005) as predictors for experiences in behavioral health [poverty, minority and racial status, and being female], African American women, despite being a minority in the total population of U.S. citizens, are more likely to experience depression and anxiety. Therefore, the likelihood of this population experiencing symptoms of depression increases dramatically within the context of considering the one factor of poverty (social class) alone.

Significance of the Study

Given the political and social climate of our nation, the United States has begun to understand that multicultural competencies and awareness are needed in order to fully integrate and uphold the values of diversity (Sue, Arredondo, & McDavis, 1992). In order to accomplish goals of inclusivity and awareness, shifts in the mental health field where persons whom work as professionals, or paraprofessionals, are becoming more prioritized as the mental health field continues to expand (“Supreme Court decision boosts field's support of Medicaid expansion”, 2012; Dworkin, 2010). It would be difficult to uphold the values and virtues emphasized in the democracy of our government if awareness to these trends become thwarted and unrecognized. (INSERT TABLE: Projection of Pop. by Sex, Hispanic Origin, and Race for US 2015-60)

Providing that the black population has not been opportune to having a high quality of life in this nation's history, it must be of relative concern to be aware of stigmas and /or likely barriers that impose on the opportunity of such. In considering factors (stigmas) that affect African American women, research has uncovered a well-known stigmatization that permeates many minority communities with the concept of interaction and exposure. Watson and Hunter (2015) explain that these stigmas are rooted in the association "... with seeking professional psychological service as a means to manage psychological distress" (2015). In fact, as seen in Watson and Hunter, Merritt-Davis and Keshavan identified economic barriers as being one of the primary reasons in explaining why African American women underutilized professional psychological services (2006). Due to an economic barrier, the pursuit of quality of life becomes difficult for any person subjected to economic disparity to pay for services that would address their concerns and could triangulate with other barriers, such depression. In fact, it has been noted that poor young women are at risk for depression, and those whom are of an ethnic minority group are unlikely to get care at all, in particular (Kessler et al., 2003). As a result, people who are able to identify with more than one demographic characteristic, such as being a woman of color, are at a disadvantage of experiencing more push back through stigmas and stereotyping, or barriers. Due to the restrictions that stigmas and barriers impose, African American women are more susceptible to having difficulty in either pursuing services or being provided those same services that are available to combat behavioral health.

As such, there are many reports and areas of research that have demonstrated how other groups are represented when analyzing the prevalence of behavioral health being present, but very few research has studied the relationship that African American women have in particular with this concept (Fay, 2016; Watson & Hunter, 2015). Therefore, this becomes beneficial for

rehabilitation and counselors alike to have a sensitivity to this information in order to properly address it as best as possible, in terms of recognizing how African American women experience behavioral health, as well as how they approach and deal with its effects. This interaction and knowledge should also challenge the rehabilitation field to becoming more willing to identify individual biases, as well as prejudices that could interfere with initiating and providing services to these individuals that seek assistance. Stone & Moskowitz (2011) lament that disparities in the health care field are jeopardized by non-conscious stereotyping and prejudice to racial and ethnic groups. Furthermore, they promote that training in implicit biases can actually enhance cultural competence by reducing biases when interacting with minority groups by being able to search for the common identities that the provider can relate to with/in the perspective of their [minority] patient. With articles and researches similar to Stone & Moskowitz becoming more prominent, it is within hopeful reasoning that African American women begin to feel comfortable in the mental health field. This would also address and confront the discriminatory factors that affect their pursuit in seeking help; Thus, this may lead women of color to feel more confident that services will be provided to the best of their ability to combat the stigmas that behavioral health can have in relation to race and gender.

Purpose and Objectives of the Paper

When looking into the ramifications of behavioral health for African American women and recognizing prevalent factors that limit the ability to secure and pursue services, it was interesting to discover a positive correlation within gender, especially when linked with race. In order to gain a better understanding of how prevalent behavioral health is within the African-American female population, alongside an introspective insight of how women of color cope with or without the services provided by professionals and rehabilitation counselors,

the focus of this research identifies the linkage and correlation of mental illnesses amongst this group. In such, investigating how depression and anxiety affects Black women, this will be accomplished by an analysis of research that has been conducted involving the conclusions that were founded to be true experiences of behavioral health for African-American woman. These three specific questions will be addressed:

1. What are the contributing factors for African-American women who experience anxiety and depression?
2. What services and/or resources are available that have been successful in rehabilitating an African-American woman who has had experiences with anxiety and depression?
3. How does this community otherwise —if no treatment is ever sought — cope without professional services?

This research paper aims to resolve and address these few questions, as well as offer a critical analysis of information that had already been founded in relevant researches and literature, in order to ensure that rehabilitation for this group is applicable. Through this analysis, it is my hope that African American women will be better received when seeking services, as well as examining the reasons of why such services may never be sought by women of color. With the inclusion of these two facets, it is my hope that rehabilitation counselors and therapists will be able to begin a dialogue that investigates how current approaches might affect the pursuit of services by minority groups, especially in relations to African American women. Once this discussion is complete, the mental health field should be encouraged to make remedies that properly address the stigmas that are attached to this particular subgroup, as well as solutions on how to combat already perceived judgments and biases. This paper can therefore be utilized as a talking point in efforts of brainstorming unique techniques and enhancing personal development

when it comes to serving this population, while also being sensitive to the struggles that are endured and felt as barriers for women of color to seek and initiate services themselves.

CHAPTER II

OVERVIEW OF THE LITERATURE

While there are many studies that indicate various reasoning as to why and how Americans can succumb to experiences with anxiety and depression, in the context African American women, such explanations can entail poverty and socioeconomic factors, race and gender, and physical safety. While all of these factors are certainly contributors to experiences with anxiety and depression, each variable is unique to African American women and may not always be experienced individually, but may be combined dually with others [factors]. All of these examples are supported by the notion provided by Kendler, Herrema, Butera, Gardner and Prescott (2003) which states that more than naught, depressive symptoms are more likely to follow events that involve loss or humiliation, all the while significantly increasing anxiety (in clinical terms) followed by events involving loss or danger. While studying the factors associated with the behavioral health surrounding African American women, several articles will examine resources, or subsets, that contribute to the perseverance of African American prevailing these conditions, which are successful in rehabilitating the symptoms of depression and anxiety. As such, if no remedy is sought by an individual to assist with sustainment, this paper will examine other areas in which African American women may look for support outside of seeking professional help.

Contributing Factors

Socioeconomic Factors

Literature supports that persistent poverty over one's life course can have adverse effects at all developmental stages, including both a child and adult's well-being (Goosby, 2007). This leads into the notion that families who are living in harsh conditions lack the social supports that

can be found in other communities, which leads into stress and manifests into depression, anxiety, and feeling a lack of control (Goosby, 2007). Presented by Miech, Avshalom, Moffitt, Wright, & Silva (1999), they produced an article that presented information revealing a notable relationship between socioeconomic status and the psychological distress which notable increases socioeconomic disadvantage when linked with mental disorders (behavioral health). This essentially leads to a higher risk of psychological distress and disorders (as cited in Goosby, 2007). Due to these pervasive classifications, African American women suffer from being at a disadvantage due to too often being classified in divisions consisting of poverty, minority and racial status, as well as being female (Frank, Matza & Chung, 2005). In a study presented by Goosby (2007), in an attempt to understand the socioemotional outcomes of adolescents entrapped in poverty's domains and the correlation of the mother's access to psychological resources, she founded that African American mothers spend more time in poverty compared to White mothers on average (p. 1130). In particular, mothers whom experience the economic hardship are more likely to have higher levels of depression and anxiety and lower levels of mastery (Goosby, 2007). This would include factors associated with employment, such as inflexible work hours, financial resources, childcare arrangements, and the added dilemmas and stresses of the perceptions of racial discrimination that have been linked to declines in mental and physical health (McLoyd, Jayaratne, Ceballos, & Borquez, 1994; Menagham, Kowalski-Jones, & Mott, 1997; Williams, 1999).

Race and Gender

Although there is still a deficit in studies that seek to interpret the African American experience in behavioral health specific to race and gender, Myers, Wyatt, Ullman, Loeb, Chin, and Prause (2015) reported that groups consisting of African Americans (including Latinos) face

ongoing adult trauma and chronic adversities, including the stresses of racism and discrimination,. These were reported as being closely associated with socioeconomic status, national origin, and/or sexual minority status. As defined by Pascoe and Smart (2009), discrimination is “a behavioral manifestation of a negative attitude, judgement, or unfair treatment toward members of a group” (p. 533). As such, there is much collected data that reflects minority groups reporting subtle and overt stressful experiences with discrimination as part of their daily lives (as cited in Myers et al.) In fact, African American women were the highest reporting group compared to their counterparts.

Where gender differences were reported, depression rates for women in the African American community were generally 25-29%, with low-income, unmarried women with children at an especially high risk for depression (Ramos, Carlson, & McNutt, 2004). When referring back to Myers et. al (2015), their article concluded that stressors in behavioral health include discrimination based on ethnicity and having multiple traumatic experiences as a result of such. In an article published by Watson, Marzalek, Dispenza, and Davids (2015), they hoped to understand the relationships among white and African American women’s experiences with sexual objectification, physical safety, and psychological distress and discovered that the experiences of sexism and sexual objectification occur only to women “...*because* they are women” (Landine and Klonoff, 1997; Klonoff and Landrine, 1995). Following this, Watson et al. (1995) explains that this is detrimental due to these experiences being solely based on identity and thus, cannot be controlled for; Race, age, ability status, and so forth, all “contribute to [the] unique experiences and reactions among various sub-groups of women” (Frederick and Roberts, 1997 as cited in Watson et al., 2015). Results from their study concluded that for the African American women’s experience with sexual objectifications, origins dated back to American

history that disparaged African American women rights to their own bodies and to subject to over sexualization. Furthermore, their interviews suggests that White slave-owners were responsible for legitimizing sexual objectification and victimization by using these sexual stereotypes against the very population that was being targeted (p. 94). As such, a system of oppression is very evident in a historical context endured by African American women, leading to Black/African American women reporting more experiences of sexual objectification than White women (Watson et al., 2015).

Consequently, research also supports the notion that African American tend to fear crime more than Whites (p.94). Due to being subjected as a double minority, African American women endure an unending history of childhood sexual abuse (CSA), incest, sexual coercion, attempted rape, completed rape, and repeated sexual victimization than White women (Kalof, 2000; scott et al., 1993; Urquiza and Goodlin-Jones, 1994; Wyatt, 1992 as cited in Watson et al., 2015). Less than a decade ago, Szymanski and Stewart (2010) held this notion to still be precise, pronouncing race and gender-related stress to be associated with the increased psychological distress amongst the community of African American women. Studies have since affirmed that higher rates of depression exists within African American women compared to White women, and experience more stress than Whites (Williams, 2010, as cited in Watson et al., 2015).

Physical Safety

As cited in Myers et. al (2015), there have been several large-scale epidemiological studies that have recently confirmed that “exposure to acute and chronic early life adversities and trauma [can be] associated with increased risk for adult psychiatric disorders” (Benjet, Borgers, & Medina-Mora, 2010; Green et al., 2010; McLaughlin et al., 2010). As an example, Chapman, Whitfield, Felitti, Dube, Edwards and Anda (2004) lament that a greater number of childhood

abuses predicts increased risk for adult depression. Modest levels of PTSD and anxiety symptoms are relatively reported, but have usually been less than the higher levels of depression that are detected in this particular group. This is especially true when including reports of childhood sexual abuse (CSA) involving penetration with women, as well as leading into adulthood (p. 248). This appears to be more relevant to African American women experiencing CSA, particularly when they are younger, due to ongoing reports and experiences with sexual abuse continuing into adulthood; In return, this adds to the significance of a relationship existing between age and mental health status (p. 248). As a result, in this particular study, African American women were concluded as having the highest adult trauma scores and the highest psychological distress symptoms scores, suggesting greater relative psychosocial vulnerability.

As a part of physical safety into adulthood, one must consider the effects of intimate partner violence (IPV) and the adverse effects that it causes in mental health in abused women. According to McCauley et al. (1995) and Plichta (1996) (as cited in Ramos, Carlson, & McNutt, 2004), IPV increases the risk for [behavioral health], including post traumatic stress disorder (PTSD), depression, anxiety, and substance abuse. Although there is a lack of information and studies that calculate how much race and ethnicity contribute to the incidence and consequences of IPV, a study by Raj (1999) found that these factors certainly contribute to the experiences of African American women in abusive relationships. According to the research published by Ramos et al. (2004), data indicated that African American women were at a greater risk for rape and sexual abuse compared to women from any other racial or ethnic group (p. 154). As such, it is documented that one of the factors contributing to this is associated with low levels of socioeconomic factors in linkage to physical child abuse (PCA), placing low SES African American women at a higher potential of risk. Therefore, among the families of African

Americans, a linkage of poverty and severe constraints of SES have been associated with child abuse (Myers, 1990 as cited in Ramos et al., 2004), including a host of [other] traumatic experiences. As a result, Ramos et al. recites that most research indicts African American women as being at a higher risk for depression within the African American community (Kessler et al., 1994; Neighbors & Lumpkin, 1990) due to these factors being heavily prevalent and targeted towards double minorities.

Services and Resources

Cognitive Behavioral Therapy - CBT

As one of the leading therapies associated with clinically reducing the levels and symptoms of depression and anxiety, Cognitive Behavioral Therapy (CBT) was developed by Dr. Aaron T. Beck during the 1960s as civil unrest and demonstrations circulated across the United States. CBT was pioneered in efforts to combat the symptoms and effects of behavioral health through a psychoanalytic approach by discovering that negative thoughts were spontaneous in depressed patients, coined as “automatic thoughts” (“History of Cognitive-Behavioral Therapy - CBT”, 2016). As explained by CBT, thoughts fell into three categories, consisting of 1) themselves, 2) the world, and/or 3) the future. Backed by Lambert, McCreary, Preston, Schmidt, Joiner, and Ialongo, N. S. (2004), CBT has the ability to be tailored to be specifically targeted to reduce anxiety sensitivity and its components. This was proven to clinically reduce triggers, recognizing the physiological signs, and managing anxiety-provoking situations with proper education (psychoeducation) in regards to the origins of anxiety through awareness of the meaning, cause(s), and consequences of such symptoms (p. 892-893). Other ways that CBT is able to combat behavioral health is through challenging destructive thoughts associated with inducing anxiety towards situational events, while decatastrophizing the

consequences of depressive, or anxiety-induced symptoms, should they occur (Lambert et al., 2004).

Social Support

While research posits the varying factors that can contribute to the mental health of African American females, the experiences of such also appear to not only alter the psychological health, but also their experiences [to those factors](Seawell, Cutrona, & Russell, 2012, p.5). Due to the constraints constituted through racial discrimination, Seawell et al. (2012) reiterate that the subjective view can be altered or “eased by relying on the support of one’s social network” (p.6). This conveys a closeness within the African American community, acknowledging that a social support network/system can include a range of individuals, including ones’ family members and friends. A benefit that was apparent was the increased efforts of communicating amongst the community, stating that African American women were more likely to talk to their friends in order to cope with racial discrimination. Cutrona and Rusell (1990) attest that this [social support] works best once it can meet the specific needs that are being imposed upon by the stressor. This is due to working as a buffer, explained as “weaken[ing] the impact of the stressor on the outcome variable (e.g., depressive symptoms)” (as cited in Seawell et. al, 2012, p.7).

Support also serves as a connective variable, allowing for personal relationships to flourish through the establishment of trust. Choe, Stoddard, and Zimmerman (2014) add that family relationships are especially influential throughout one’s development, specifically when positive adaptation is reliant on one’s well-being (p.1229). This outcome supports the notion that stressors can be reduced through trusted relationships, especially when self-esteem is present. According to Dr. Gordon, a nurse therapist, it was believed that risks for depressive symptoms

originated from “spiritual, physical, and emotional factors”. This asserted the crucial role that relationships can have and that by improving one’s self-esteem, social support is more sustainable and therapeutic. Through the results of a qualitative study researched by Borba, DePadilla, McCarty, Silke, & Sterk (2012), many of their mental health providers concluded that a centrality of them providing access to medical healthcare services was ensured through building trusting relationships. Therefore, social support was deemed a being a “meer determinant to get[ting] women engaged with the healthcare system”. In addition, as an extra layer of protection, this not only benefits and improves behavioral health, but is linked to improved physical health, as well (Mastropieri, Schussel, Forbes, & Miller, 2015).

Brown, Bromberfer, Schott, Crawford, & Matthews (2014) analyzed mid-life African American and White women over the course of 11 years and incited that findings were consistent with prior research, indicating that more African American women experienced seen or more episode of depression that did Caucasian women. Research also concluded that, despite this difference, few African American women sought clinical help for mental and behavioral problems, including any engagements with psychotherapy or pharmacotherapy, supporting the deficit of racial disparities as being present in mental health service use.

Persona

Watson and Hunter (2015) studied that, generally speaking, African American women do not seek professional [and] psychological services in order to cope with psychological distresses. As such, their research identified a cultural factor, described by empirical findings as the Strong Black Woman (SBW) race-gender schema. SBW implies that African American women have been prompted to “exhibit strength, self-reliance, and self-silence in response to stressors (Beauboeuf-Lafontant, 2007; Black & Peacock, 2011; Harrington, Crowther, & Shiperd, 2010;

Woods-Giscombé, 2010; as cited in Watson & Hunter, 2015). It is claimed that these coping strategies help to reduce the negative attitudes towards seeking help when behavioral health, in terms of intensified depression and anxiety, are present. Through historical perseverance in reference to slavery, SBW has been respected as a central aspect of an African American women's ability to triumph in various forms of oppression, while encouraging continued plights towards excellence and strength and can induce feelings of self-efficacy. In fact, through this study, SBW was identified as influencing the course of, and recovery, from anxiety, amongst African American women. Although sole reliance on SBW could be damaging towards the attitudes of seeking clinical help, in combination of other forms of resources, African American women that continue to build their self-esteem and confidence, despite the burdens of society's impact, are able to thrive and seek assistance with their behavioral health concern(s).

CHAPTER III

DISCUSSION AND IMPLICATIONS

When studying the contributive factors of anxiety and depression as behavioral health, Howe, Hornberger, Weihs, Moreno and Neiderheiser noted that these two disorders could co-occur frequently (2011). Accounting for roughly 13.3% of the total population in the United States, African Americans make up the largest racial minority, according to the 2015 reports from the United States Census Bureau (QuickFacts, 2016). As a result, current research indicates that women identifying as African American “have higher rates of depression and anxiety compared to White women” (Watson, Roberts, &Saunders, 2012; Hamm, 2014). With this information, there are significant factors that have been identified as contributing to the overall well-being of African American women in behavioral health, including SES, race and gender, and the presence of physical safety. Due to those who have behavioral health concerns, women are more likely to experience higher rates of physical and medical disorders than those in the general population (Kessler et al., 2003 as cited in Borba et al., 2012).

In an effort to clinically safeguard against these social standards, some resources that are available to combat these factors include a combination of Cognitive-Behavioral Therapy, social support, as well as the holistic persona of a strong Black female. Although the latter can not be independently relied upon, the combination of all three resources, or combined with one other, have been supported through research as benefiting the experience of an African American women who has behavioral health concerns and would like to seek clinical services that could alleviate their concerns. Many times, it is reasoned that African Americans holistically prefer to rely on their individual desire of solving their own problems, which presents as a huge barrier to the overall utilization of mental health services. This also correlates with the belief that there are

no concerns for behavioral health that would create the need for treatment (Thurston & Phares, 2008). As such, it was determined through a study provided by Paul and Moser (2009) citing that stressful events are in fact strongly associated with, as well as being respectively predictive, of both depressive and anxiety disorders. Brown et al., (2014) supports the use of CBT, finding this as a useful strategy that could focus on specific risk factors that induces behavioral health concerns, by deeming CBT could help to enhance African American women's ability to enhance their adaptive attributions, such as optimism.

Davey and Watson (2008) agree that there are many ways that African Americans can be engaged in therapy through use of implementing a public policy and mental health model. With such, some of their suggestions entailed addressing attitudes attributed towards mental and behavioral health. They noted that attitudes that are adopted are one of the many barriers to seeking mental health care, implicating that by acknowledging the demographic characteristics, beliefs, attitudes, and attributions, cultural mindset, and local network, African American community have multiple ways in which to be integrated into having access to mental health services through clinical means. Unfortunately, this information does not depict the ongoing trends in the United States. Instead, within the last decade, the surgeon general's report reveal disparities between mental health services and racial/ethnic minorities and Whites. They found that services had been less available to minorities; minorities had less access to services, and yet were also less likely to receive mental/behavioral health services or would be subjected to receiving poorer treatment (Snowden, 2001). Not only does this imply that racial disparities are still present and active in the United States, but it would also insinuate that the behavioral health of a minority, can be at the fault of socially accepted stigmas and dogma imposed upon society, originally influenced by the White population in which it historically commenced from.

Future research should include more studies that seek the best practice that improves engagement from minority clients while also providing ongoing support to cultural sensitivity training for their providers. This would simultaneously provide both knowledge and awareness to providers and encourage those to identify stereotypes and prejudices within ourselves, but would also stimulate productiveness in our services. Not only would we [providers] be challenged to combat these self-thoughts, but also would encourage use to seek innovative ways to communicate with a population who has faced so many barriers, yet still sustain strength regardless of society and self-imposed limitations. As such, such trainings could positively impact the provider's perspective, but I would hope that the client/patient's perspective could also be impacted, opening a door for positive and supportive relationships to ensure to providing better care for individuals seeking services. I would also recommend more research specifically on African American women's plight with either behavioral health, as much of the research that was included in this forum was dated, or synopsis of building upon prior research. Many articles disclosed that there was limited information on this subject, and were subjected to using dated material, or completing quick researches to produce data and information. Lastly, African Americans should continue to assert themselves within communicates that differ from their own, challenging both society's stereotypes and biases, as well as their own, to continue growth from stagnant attitudes, as well as continuing the plight for overall success in addressing behavioral health.

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