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A Qualitative Exploration of African-Americans' Attitudes Toward Mental Illness and Mental Illness Treatment Seeking

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This article presents data from a qualitative study of mental illness attitudes and mental health service use in a community sample of African-Americans (N=70). Specifically, we examined cultural factors that shape community norms, including mental illness stigma, attitudes and behaviors. Focus groups were used to examine the influence of culture on broad thematic categories associated with mental illness and mental health service use. The following five thematic categories were examined: (a) descriptive terms and causes of mental illness, (b) cultural norms regarding mental health, (c) attitudes toward mental health service use (d) presence and determinants of mental illness stigma, and (e) strategies for reducing mental illness stigma and increasing access and use of mental health services. Thematic categories were selected based on the applicability of the information for education and stigma reduction intervention programs. Study findings have relevance for the development of culturally appropriate education and stigma change interventions for African-Americans.

In recent years efforts have been undertaken to increase the public's understanding of mental illness and appropriate use of available mental health services (USDHHS, 1999; 2001). Among these efforts is a call to examine the role of culture on belief and behaviors associated with mental health (Schnittker, Freese, & Powell, 2000). Culture plays a significant role in mental health concepts including attitudes about mental illness, how symptoms are described, appropriate illness response, availability of support and willingness to seek treatment (Parham, 2002; Sue & Sue, 2003).

An important but understudied area of cross-cultural research in mental health is the relationship between culture and mental illness stigma (USDHHS, 2001). Thus far, much of the research on mental health stigma has been completed on
adult samples largely drawn from majority ethnic groups. As such, little is known about the presence, predictors, and influences of mental illness stigma among ethnic minority group members. The focus of this paper is to examine cultural factors associated with African-American’s attitudes and beliefs associated with mental illness and mental illness treatment, including stigma. Study findings have relevance for the development of culturally appropriate education and stigma change interventions for African-Americans.

**Mental Illness Stigma and Mental Health Service Use**

Several factors influence a person’s attitudes toward seeking health care services including social perceptions (Andersen, 1995). Social stigma is generally thought to reflect “any discrediting attribute that disqualifies a person from full social acceptance” (Goffman, 1963). As it relates to mental illness, stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness (Corrigan & Kleinlein, in press). Mental illness stigma contributes to disparities in life opportunities, physical health and emotional well-being of persons with mental illness compared to persons without mental illness (USDHHS, 1999).

In addition to the social burden incurred, mental illness stigma discourses major segments of the population from seeking needed services (USDHHS, 1999; Sirey et al., 2001). For example, national epidemiological studies suggest that mental illnesses affect one-in-five Americans at some point in our lives. However, only one-third of Americans with a mental health problem get needed care (Kessler et al., 2001).

A recent report by the U.S. Surgeon General (USDHHS, 2001) concluded that ethnic minority group members may experience a greater burden from unmet mental health needs compared to European Americans due to the combined influences of reduced access to care, lower quality of services received, and reduced voluntary utilization of mental health services. The report also pointed to the importance of understanding the role of cultural and social factors in the development, experience, and recovery from mental health problems. Specifically, the report noted that stigma generated beliefs and practices within African-American communities should be systematically explored with appropriate interventions and evaluations. Understanding cultural factors associated with attitudes toward and use of mental health services is an important aspect of reducing mental health disparities (Corrigan & Rusch, in press).

**Culture and Mental Illness Stigma**

Among African-Americans a range of barriers to mental health service use have been identified including: financial constraints and lack of available services (Greenly, Mechanic, & Cleary, 1987); higher levels of mistrust of the mental health system (Snowden, 2001); low acceptance of medications (Vitiello et al., 2003); negative attitudes toward and low perceived efficacy of treatments (Nickerson, Helms, & Terrell, 1994); fear of hospitalizations (Pescosolido et al., 1999); and lower rates of detection of African-American’s mental health problems by primary care providers (Borowsky et al., 2000). In addition, research suggests that attitudes toward mental illness and mental health service use by African-Americans are as unfavorable, or even more so, as the attitudes held by whites (Schnittker, Freese, & Powell, 2000).

Further, studies suggest that mental illness and mental health treatment are associated with high levels of stigma within the African-American community (Gary, 2005). However, other investigators examining how mental illness stigma interacts with ethnicity have suggested that African-Americans are less likely to endorse the stigma of mental illness compared to European Americans (Corrigan et al., 2001; Diala et al., 2001). Given the equanimity in the literature, qualitative research may provide important insights into some of the cultural determinants of attitudes and behaviors associated with mental illness, including mental illness stigma.
Specific Aims

Study objectives were to describe the norms, attitudes and behaviors of African-Americans regarding mental health and mental health service use. We a framework approach to qualitative research to examine the influence of culture on five broad thematic categories associated with mental illness, including stigma. A framework approach is used in qualitative studies when information is being sought to inform an apriori set of objectives (Ritchie & Spencer, 1993). Thematic categories were selected based on the applicability of the information for education and intervention programs aimed at increasing access to mental health services for African-Americans.

The following five thematic categories were examined: (a) descriptive terms and causes of mental illness, (b) cultural norms regarding mental health, (c) mental health service use (d) presence and determinants of mental illness stigma, and (e) strategies for reducing mental illness stigma and increasing access and use of mental health services. Study findings have implications for the development of culturally appropriate education and stigma change intervention approaches.

Method

Overview of focus group methodology. Qualitative methods such as focus groups are useful tools for investigating a new area of research, designing questionnaires, developing new intervention protocols, and interpreting findings (Denzin & Lincoln, 2003). In a focus group, relatively homogenous groups of participants are brought together to discuss a specific topic (Denzin & Lincoln, 2003). Unlike a probability sample-based survey, the unit of analysis in the focus group is the group, not the individual (Krueger, 1994). As such, the observations drawn from individuals are not independent nor are the individuals or the groups a probability sample from a known population (Krueger, 1994). Specific guidelines for overall sample size in focus group studies have not been established. Nonetheless, Morse (2000) suggests that a total of 30-40 participants provide sufficient breadth of input to explore a new area. More important, saturation of themes is a better determinant of whether additional focus groups should be conducted rather than a given number of study participants (Guest, Bunce & Johnson, 2006). Saturation refers to the point at which no additional themes are generated when data from additional participants are included (Guest, Bunce, & Johnson, 2006). Saturation was achieved in terms of new themes and diversity of opinion with our sample of 70 participants.

Study participants. The data for this study were collected as part of the Anti-Stigma Program conducted by the University of Chicago and the National Association of Advancement of Colored People (NAACP). Focus groups were conducted from July 25 to October 15, 2002 and included participants from a predominantly lower income African-American community on the west side of Chicago. Seven focus groups (N = 70) were conducted with members of the following groups: mental health providers (N = 9), ministers and religious leaders (N = 4), mental health consumers (N = 13), Baptist church members (N = 9), Episcopalian church members (N = 10), lay community members (N = 10), and members of an African-American civic organization (N = 15). Data were analyzed in the aggregate for all groups.

Recruitment. Participant recruitment was conducted in a predominately African-American community in a large urban setting. The Westside Anti-Stigma Community Advisory Committee was formed to assist in the identification of community stakeholders and recruitment of study participants. Four stakeholder groups were identified as essential for changing attitudes and behaviors in the African-American community and were targets of recruitment efforts. These included religious groups (ministers, church members), civic organizations (African-American civil rights organization), mental health system (mental health providers, mental health consumers), and community groups (lay community members). Members of the Advisory Board placed project adver-
municated both directly and indirectly by family and community members. Willingness to disclose mental health problems or to seek formal help for one’s problems was generally “unheard of.”

“How are we taught to cope? Be strong and bear with it. Get over it. Keep going. Pray. You can’t break down. You just keep putting up a front. These are the ways we were taught to cope.”

“These things [ways of coping] are passed on from generation to generation. Like my parents, they handled it, and I handled it with my kids and they handled it with theirs. Most of the time they didn’t seek help. It was just unheard of when I was a kid.”

Culturally shaped self-images. Previous studies involving African-American women (Greene, 1994; Matthews, 1998) suggest that culturally shaped self-images such as the “strong black woman” can decrease the amount of emotional support available to African-Americans and discourage the perceived need for and acceptance of formal or informal mental health assistance. Swigonski (1995) points out that the ability of women of color to cope under the worst conditions and culturally prescribed roles can mask their need for support, or the recognition of others that support is needed, and act as a barrier to effective treatment.

“I don’t think black women realize when they have a mental health problem because we’re just so accustomed to doing everything that we just don’t get help. You just keep going until you crash and burn and then you say, ‘oh, something’s wrong.’”

“African-American women, especially, have very full plates. They often don’t have the time to take care of themselves because everyone is dependent on them.”

“When we were younger, if we had food and clothing everything was fine. We didn’t understand that if Mother cried all night, she could have been depressed. We didn’t understand that this was not normal.”

Religious coping. Compared to other Americans, African-Americans generally have higher levels of religiosity and use of religious and spiritual coping strategies (Steffen et al., 2001; Bourjolly, 1998; Koenig, 1998). Reliance on religious beliefs or spirituality was strongly endorsed as a coping strategy by most participants. Although the groups consisting of ministers and church members were more likely to stress the formal role of the church and religion in addressing mental health problems, most participants focused on the more general role of spirituality as a coping resource.

“A lot of older people are still relating back to when it was bad to have somebody in the family that was mentally ill or retarded. They discouraged help seeking. They believe the Lord will take care of the problem. They don’t understand that medication and prayer will work.”

“He [The Lord] says bring them [your problems] to me and leave them here and I’ll take care of them. That’s a state of mind you have to be in, that’s an African perception.”

Informal coping resources. The tendency of African-Americans to rely on informal supportive systems such as family or friends has been previously documented (Boyd-Franklin, 1989). Reliance on kinship and non-kinship group members evolved as a strategy by African-Americans to combat the lack of access to mainstream sources of professional support (Miner, 2000). The importance of informal support systems appears to persist as a valuable resource within the African-American community.

“Many times people are more comfortable with their family. Staying within the family you feel an extra bond there.”

“My kids started what they called “Sister Night.” They would get together to eat, play music, and talk about their problems.”

“I have a sister who lives in another state. She’s someone I can vent to and I don’t have to worry about it getting all over everywhere.”

Maladaptive coping. The self-medication hypothesis is frequently used to explain research findings of higher rates of alcohol use and alcohol-related problems among oppressed minority groups (Hughes & Wilsnack, 1997). A perceived over-reliance by African-Americans on maladaptive coping strategies such as “drinking and partying”, “eating too much and too often”; and “using
drugs as a means for solving problems” was reported by focus group participants. The presence of social ills like substance abuse was thought to stem from the greater burden of stress associated with racism experienced by African-Americans and the reluctance of many African-Americans to acknowledge mental health problems and access needed services.

**Mental Health Service Use**

The extant literature suggests that African-Americans underutilize mental health services relative to need (Snowden, 1999). Development of effective interventions to increase use of services in this population will necessitate identification of barriers, both external and internal, to obtaining treatment for psychiatric disorders. The following section describes attitudes and beliefs associated with use of professional mental health use and barriers to care. Consistent with the Surgeon General’s report on Mental Health (1999), reported barriers included lack of awareness, cost of services, cultural beliefs and attitudes regarding mental illness and treatment seeking, system level factors, and mistrust.

**Awareness.** Study participants discussed two aspects of awareness that serve as barriers to receipt of mental health services. The first was the lack of knowledge about the availability of effective treatments for a wide range of mental health disorders. A second but related issue was the lack of awareness about the availability and location of mental health service facilities within their community. Combined, these two factors were viewed as significant barriers to increasing access to and utilization of mental health services by African-Americans.

“There’s a real lack of awareness in the community about mental health problems and how to identify it and how to get our children and ourselves into some assistance.”

“The mental health center has been here in the neighborhood for 20 years — same length of time as the medical center but no one even knows it is here.”

**Costs.** Economic factors were also reported to play a major role in the mental health treatment use of African-Americans. Limited monetary resources and lack of insurance coverage were viewed as contributing to delays in mental health treatment seeking. Further, there is an impression that the lack of resources and advertising in the African-American community is fueled by the profit motives of mental health providers.

“In the White community you don’t have to seek it out [information about mental health services]. There are signs on train stops, billboards, and people passing out flyers. I think the reason that it’s different in the Black community is because providers believe that people in [neighborhood X] don’t have money to pay for services.”

**Cultural beliefs about mental illness and mental illness treatment.** Many responses to questions regarding individual and community attitudes about mental illness and mental illness treatment seeking were negative. Participants reported high levels of embarrassment, refusal to accept the need for services, and stigma associated with mental illness and treatment seeking.

“People are afraid to show weakness, to show they can’t handle something. It’s like a defeat.”

“They would have to take me out [incapacitate the person to get them to treatment]. It’s something in me that rejects going in and saying I’ve got a problem. It’s like admitting a weakness.”

Many of the negative reactions described by focus group participants were related to cultural attitudes and misconceptions about mental health treatment. Viewing community-based mental health as a means to assist with problems of everyday living was limited and in most cases rejected as an accepted practice among African-Americans.

“Only whites have the luxury to sit around and talk. Black people have to keep moving to stay alive.”

In addition, any reference to receipt of mental health treatment was viewed as synonymous with “being crazy” and being hospitalized in a state psychiatric facility. Further, many of the focus group participants felt the image African-Americans have of mental illness is so severe that most individuals are unable to identify “mental health disorders”
System factors. Numerous system-level factors were described as barriers to mental health service use. The first related to personal experiences with individual mental health providers. A common sentiment expressed by respondents was the perception that mainstream mental health providers do not have the skills or expertise to work effectively with African-Americans. Further, participants reported leaving a clinical encounter feeling “interrogated” instead of understood and assisted by their provider. Whether intentional or otherwise, the questions asked by providers were often viewed as attempts to obtain evidence of criminal behavior rather than providing treatment. Provider behaviors, coupled with the reality that many minority patients are mandated for treatment rather than self-referred (Akutsu, Snowden, & Organista, 1996), have contributed to the perception of mental health services as punishment rather than treatment.

“At the juvenile detention center, 90 percent of the children are African-American. I feel that they’re not getting the proper mental health care. There is not one black provider there that would understand the background and heritage of the kids.”

“There is a kid [at a treatment center] that tries to kill himself every chance he gets. They say, ‘Oh, he just wants attention’ because they don’t understand our kids.”

“I took my foster child to see a psychiatrist. He asked the child, “Is Ms. X., mean to you? Do you have enough to eat? Who else lives with you? All questions investigating me as opposed to finding out how the child was feeling.”

Mistrust. Mistrust of doctors and the medical community, particularly among older generations, was cited as another major hindrance to seeking mental health services. Although there were discussions about historical abuses, current concerns were primarily driven by perceptions of ongoing racism within the medical establishment and a perceived disregard by the mental health community for the mental health needs and concerns of African-Americans.

“They treat you according to race. They say he’s from this environment so we’re going to give him a stronger dose of Haldol or Cogentin and that will keep him calm and then we’ll discharge him.”

“When someone gets shot in the suburbs teams of psychologists and social workers come in to the community to give them therapy. Kids in the inner city see folks get shot and killed all the time and sometimes it never makes the news.”

Related to mistrust were beliefs about the efficacy of treatments and ability of mental health providers to assist African-Americans with their problems. These doubts were reinforced by the negative beliefs of friends and family members and contributed to treatment refusal or the premature termination of therapy.

“Even though a person seeks help, you’re not too confident in the help that is given.”

“Nothing that a therapist says would help anyway. I don’t want him in my business. I don’t want a stranger in my business.”

“You’re told, ‘You’re wasting your money. If I were you, I wouldn’t go back.’”

Presence of Mental Illness Stigma

Stigma associated with mental illness was reported by focus group participants to be a pervasive problem in the African-American community. Mental health consumers who participated in the study spoke at length about the detrimental impact that mental illness stigma had on their lives. Consumers most consistently focused on the psychosocial consequences of mental illness stigma such as shame, embarrassment, and rejection following disclosure of their illness.

“My illness started when I was four years old. My parents didn’t want anyone to know so they would keep me hidden when company came over because they were embarrassed.”

“I was so embarrassed about taking medications. When people came to my apartment, I would run and pick up my medication and hide it in the closet so they wouldn’t see it.”

“I made the mistake of telling my best friend. He said, 'you’re crazy? Oh my God, I can’t believe it. Get away from me. You’re dangerous.’”
Study participants without a personal experience with mental illness seemed to relate most to stigma as a barrier to mental health help seeking or acceptance of the need for a family member to receive services.

“I wouldn’t accept that my son needed help. I’m ashamed to say that I needed to get past what his label would mean for my reputation before I would go and get his needs taken care of.”

Social distance in the African-American community between persons with mental illness and those without mental disorders was described as a consequence of mental illness stigma. Social distance was maintained out of fear and a desire to avoid being personally stigmatized by associating with a person with mental illness. Despite a high social avoidance of persons with mental illness, participants were also able to have some level of empathy regarding the negative impact that social rejection has on persons with mental illness.

“People screaming and hollering and talking at top volume; shaking their hands; acting erratic; people just drive away from situations like that. They don’t want to talk to them.”

“People think, ‘let me just stay away from you because I don’t want anyone looking at me they way they are looking at you.”

“If you see someone who is acting odd or different, then we just look the other way. Nobody wants to get involved. They’ll say, ‘he’s crazy. I’ll just stay as far away from him as I can get. ‘But a lot of time, people just need help and understanding.’”

**Determinants of Mental Illness Stigma**

Study participants discussed multiple determinants of mental illness stigma. One prominently discussed theme was the inter-generational transmission of attitudes and misinformation about mental illness. Specifically, stigma associated with mental illness was thought to have evolved from the beliefs of older generations and is being passed down to subsequent generations by direct messages about the importance of self-reliance in coping with life problems, etiological frameworks for the development of mental illness, negative consequences of being labeled as “crazy”, the cultural value of keeping and solving problems within the family, and importance of prayer and faith in overcoming life problems.

“This [beliefs about mental illness] is something we’ve been taught and it gets handed down. It’s now part of our culture.”

Another determinant of mental illness stigma is the informational deficit in the African-American community regarding mental illness. Due to a confluence of issues, some subsections of the African-American community have become informationally closed systems (Laumann & Youm, 1999). Such systems have poor access to mainstream sources of health information that are more readily available to individuals residing outside of these systems. Consequently, informational deficits become accentuated and cultural values and teachings play a larger role in shaping the knowledge base and behaviors of community members.

“The average person on the street would not recognize the symptoms of depression. And if they did they would ignore it.”

“In the black community a lot of us are illiterate about mental illness. When you hear mental illness, it means you’re crazy, you’re a lunatic, you don’t know what you are doing.”

The loss of social status associated with a mental illness diagnosis is another determinant of mental illness stigma. The perceived negative social implications of having a mental illness or seeking mental health services were widespread. As previously noted, a history of mental illness was thought to reduce one’s social standing and life opportunities.

“I think most people don’t think it’s anything that is curable. You think once they’re crazy, they’re always going to be crazy. You’re always going to sort of keep one eye on them. Even if they’re doing all right and they’ve got their life together ...”

“I don’t care who you are, I don’t care how sharp you come in, they’re going to feel they know she was crazy and they’re going to continue to bring that up. But you can go out there and be a drug addict and it’s different [you can recover your former status].”

Rehabilitation Education
Implications of Findings for Program Development

Table 1 provides a summary of the key findings from the qualitative data. Based on study findings, an important first step in reducing mental health disparities is to improve public awareness about the effectiveness and availability of mental health services. Consistent with the extant literature (e.g., Snowden & Thomas, 2000), our findings suggest that a substantial proportion of African-Americans may not be aware of available services; may not understand how treatment can improve their adjustment and ability to cope; or may perceive mental health treatments to be of low effectiveness. Based on study findings, improving attitudes by increasing knowledge and understanding about mental health services will be a necessary component of reducing barriers to treatment.

"Educate the public about mental illness. It should be more like it is in the white neighbor-

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Table 1
Summary of Qualitative Findings

1. Definitions and explanatory models of mental health
   a. Descriptors of good mental health included: “happy,” “stable,” “having a positive attitude” and “good spiritual health.”
   b. Terms describing those experiencing poor mental health included: “withdrawn”; “stressed”; “unable to cope”; and “weird behavior.”
   c. Participants, in their definitions of severe mental illness, were less able to draw a distinction between those suffering from experiences that affected mental health and those experiencing a severe mental illness.
   d. Psychological explanatory models of mental illness were endorsed.

2. Culture and mental health
   a. Culture seems to play a major role in coping styles and strategies endorsed.
   b. Themes associated with coping included: self-reliance, self-image, religion and spirituality, informal support systems, and maladaptive coping strategies.
   c. Each of these themes served as a barrier to, substitute for, or altered the perceived need for formal mental health services.

3. Mental health service use
   a. Barriers to treatment included lack of awareness, costs, cultural beliefs and attitudes regarding mental illness and treatment seeking, system level factors, and mistrust.
   b. Participants reported high levels of embarrassment, refusal to accept the need for mental health services, and stigma associated with mental illness and treatment seeking.
   c. Use of community-based mental health as a means to assist with emotional problems was limited and in most cases rejected as an accepted practice.
   d. Being labeled as mentally ill was perceived to be linked to reduced life opportunities.
   e. There were generally strong and consistent negative attitudes about medication use.

4. Presence and determinants of mental illness stigma
   a. Stigma associated with mental illness was reported to be a pervasive problem.
   b. Mental health consumers described the detrimental impact that mental illness stigma had on their lives including shame, embarrassment, and rejection.
c. Social distance between persons with mental illness and those without mental disorders was described as a consequence of mental illness stigma.

d. Determinants of mental illness stigma included inter-generational transmission of negative attitudes, misinformation about mental illness, and informational deficits.

5. Strategies for increasing access to mental health services
   a. Increasing education and awareness about mental illness in the communities.
   b. Enhancing education via social contact with persons with mental illness.
   c. Including mental health information as part of larger health education forums.
   d. Providing services in familiar community-based settings.
   e. Exploring strategies to reducing mental illness stigma.

hood. You see on billboards “are you suffering from depression, here’s the number you can call. In African-American communities the billboards advertise wine and whiskey.”

Previous studies have suggested that educational programs should provide messages targeted to African-Americans that address specific cultural beliefs and barriers (Kreuter, Strecher, Glasman, 1999). Similarly, our participants expressed a strong preference for education and services that are specifically targeted toward African-Americans.

“Make a public service announcement about places that I, as a black woman, can go and get with somebody that can see what my struggle and problems as opposed to going to somebody white that may not know the problems of black people.”

In addition to culturally tailored messages, focus group participants suggested that community-based mental health education programs should include the following themes: “Teach people you don’t have to be ashamed.” “Teach people that people with mental illness are productive and want to be a part of the larger community.” Teach that seeking services doesn’t mean “you are crazy”; “Teach people that one is not above the other — we’re in this together.”

In addition to content themes, suggestions were made that were thought to increase the value and acceptability of educational programs. Participants felt that community members may be less likely to attend a program that was exclusively focused on mental health. As such, mental health education should be presented as part of a larger health education program.

“Bring the issue of mental illness into a more public forum, such as expos and community events. I think people would attend if it were part of a larger forum.”

Secondly, there was a strong preference for changing the language used to describe mental health treatment. Some group members, especially older participants, disliked the use of the term “mental health services” and preferred “behavioral health” or “supportive services.”

“It’s the phrase “mental health”; people associate it with being crazy.”

“I don’t think African-Americans are able to accept the stigmatization that comes with the phrase ‘mental health.’”

“In the White community, they don’t call it mental health. They call it support groups so it’s not on anyone’s record.”

Finally, participants suggested that educational sessions should reduce misinformation by providing basic education about mental illness that challenges the notion that all persons with mental illness are out of control, that they are unable to function in society and manage their own lives, and that mental disorders are incurable.

“[They need to know that] Mental illness is a disease. That it is preventable and treatable. That it’s not your fault. And that you’re not the only one that has this problem.”

“The community needs to realize that people
with mental health problems can achieve goals just as they can. That we [consumers] are no different. We’re just as human.”

A second strategy is to reduce the unmet mental health needs of African-Americans is to increase access to mental health services. The U.S. Surgeon General described strategies to facilitate entry into treatment for members of the general population including increasing the availability of a wide range of services that are located in community settings, reducing financial barriers to treatment, and eliminating institutional barriers to treatment (USDHHS, 1999).

Findings from the current study support the emerging literature on the importance of religion and spirituality in coping (Miller & Thoresen, 1999) and the potential role of religious institutions in addressing mental health needs of African-Americans (Brashears, 2000). This strategy would require increasing awareness of need and acceptance of services by ministers and integration of services within a traditional religious framework (Queener & Martin, 2001). Participants from the religious community agreed that education is critical to reducing mental illness stigma and religious leaders can address mental health as part of their sermons.

A variety of additional community locations were described as appropriate for education sessions. Most frequently noted were schools, churches, field houses, and libraries. Appropriate targets for education programs included members of the community, family and friends, employers, church, and persons with mental illness. Outreach strategies should include community billboards, health fairs, and events.

Reduction of mental illness stigma is another important strategy for addressing the mental health needs of African-Americans. In recent years, efforts to reduce the negative psychosocial consequences of mental illness stigma have been undertaken (e.g., Corrigan & Penn, 1999). Controlled studies have examined the differential influence of three types of stigma change strategies: education, contact, and protest. Education and contact with persons with mental illness both have a positive effect on reducing mental illness stigma among college students; social contact has been shown to have a somewhat longer impact on attitude change (Corrigan & Penn, 1999). Although these findings have important implications for improving the lives of persons with mental illness and reducing barriers to services, little is known about the effectiveness of these strategies for African-Americans.

As perceptions of stigma are potentially changeable (Corrigan & Penn, 1999), one important implication of these study findings is that mental illness stigma may be a useful target for intervention with the aim of improving treatment seeking, adherence and mental health outcomes for African-Americans. Data from the focus groups provide strong evidence of the prevalence of mental illness stigma within the African-American community. Findings also provided preliminary information about the potential receptivity of African-Americans to established anti-stigma strategies and the need to culturally tailor intervention programs.

In general, focus group participants were very positive about the role of education in increasing mental illness awareness and tolerance toward persons with mental illness. Social contact and exposure to persons with a mental illness was also well received as a strategy for reducing mental illness stigma and increasing access and use of mental health services. Including consumers was thought to increase interest in the presentation and due to two valued practices in the African-American community — the religious and cultural practice of “giving testimony” and the cultural value of honoring “lived experience” over the opinion of experts.

“Anytime you can put a face to an issue, it’s positive because it has some impact on the people that are there.”

**Conclusion**

By understanding cultural variations in attitudes, beliefs and behaviors associated with mental illness, mental health professionals and researchers can more effectively implement strategies to increase access to care for African-Americans. A number of important themes emerged from the qualitative data that have implications for increasing access to mental health services among Afri-
American-Americans. Primary among these themes is the presence and consequences of stigma associated with mental illness. Reducing mental illness stigma as a barrier to utilization of formal mental health services is an important avenue for increasing access to services for the American population in general as well as racial and ethnic minority group members in particular (USDHHS, 2001). Research on stigma change strategies have documented success in reducing stigma associated with mental illness (Corrigan, in press).

For example, studies have shown that relatively brief education programs can lead to significantly improved attitudes about mental illness (Corrigan & Penn, 1999). Culturally tailoring educational and intervention programs to targeted populations has been shown to increase the effectiveness of such programming (Kreuter, Strecher, & Glasman, 1999). However, it is important to note that the degree to which behaviors are linked to cultural factors and the appropriate strategies used to achieve cultural appropriateness vary widely (Pasick, D’Onofrio, & Otero-Sabogal, 1996). As such, future research needs to more directly examine the impact of public stigma on acceptance of mental health services by African-Americans and determine the most efficacious strategies for reducing the negative impact of stigma.

Although, the study findings make a contribution to the extant literature on African-Americans and mental health, limitations of the study should be noted. The first relates to the sample recruitment and sample characteristics. A convenience sampling strategy was used to recruit and obtain the study sample. Although we achieved good diversity in the sample in terms of age, education, and income, the majority of participants were female and from an urban setting. The homogeneity of the sample in these two key demographic domains paired with the lack of a comparison group limits generalizability. Future studies should be conducted to determine how these findings generalize to larger more representative samples of African-Americans. Further, cross-cultural research is needed to test the hypotheses generated in this paper and to determine if responses to mental illness and the mental health system are a function of ethnicity per se or a third variable such as poverty or a general societal discontent with the mental health system.

References


Pope, C., Ziebland, S., & Mays, N. (2000). Quali-


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