SYSTEM INTERACTIONS AND MENTAL HEALTH OUTCOMES: RURAL AFRICAN AMERICAN MEN WITH SERIOUS MENTAL ILLNESS, THEIR SOCIAL SUPPORT NETWORKS, AND COMMUNITY MENTAL HEALTH AGENCIES

BY

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DISSERTATION

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ABSTRACT

African American men with serious mental illness experience disadvantages in mental health care resulting from both race and gender. The intent of this research is to better understand how rural African American men with serious mental illness and their social support networks interact with each other and the institutional context of services and how this impacts mental health treatment experiences and outcomes. Two sets of respondents participated in in-depth qualitative interviews: Twenty-six rural African American men with serious mental illness and 26 members of the men’s social support networks. Thematic analysis was used to code the transcribed interviews and identify themes about system actions and interactions. Though social supports were involved in clients’ everyday lives, they were largely excluded from interactions with the community mental health agency (CMHA) staff and client treatment decisions. This research hypothesizes that failure on the part of CMHAs to collaborate with social supports results in a lack of knowledge about mental illness and mental health care in the African American community which impedes service access and client retention.
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TERMINOLOGY

Blacks and African Americans

Though the terms Black and African American are used interchangeably in lay discussions in America, the terms have developed specific meanings for researchers studying issues impacting Blacks and African Americans. The term Black is used to refer broadly to the African diaspora, Africans and people of African descent throughout the world (Griffith, Neighbors, & Johnson, 2009). Neighbors, Caldwell, Williams, et al. (2007) note that “people of color are as likely to differ from each other as they are to differ from White Americans” (p. 486). Therefore, in the last decade health and mental health researchers in the United States have made more of an effort to distinguish whether their data was collected from a Black American sample or a more specific Black ethnic group such as African Americans, Caribbean Blacks, etc. This paper will observe the intentional use of this vocabulary but will defer to the terms applied by the original authors when discussing specific research findings.
CHAPTER 1
INTRODUCTION

African American men inhabit a persistently marginal status in American society where mental health care disparities related to race and gender overlap. “African Americans with severe mental illness are less likely than Euro-Americans to access mental health services, more likely to drop out of treatment, more likely to receive poor-quality care, and more likely to be dissatisfied with care” (Whitley & Lawson, 2010, p. 508). African American men are also less likely to seek mental health care than women due to pressures associated with “hegemonic masculinity” socialization that defines men as physically and emotionally tough (Addis & Mahalik, 2003; Connell, 1987). This research focuses on rural African American men with serious mental illness in order to better understand and serve this neglected population. One of the hurdles that currently inhibits better care for African American men with a serious mental illness is limited knowledge about how the institutional context of services and the social context of everyday life interact and impact ongoing decisions to engage in treatment (Cauce et al., 2002). The intent of this research is to better understand how the social support networks of rural African American men with serious mental illness (AAM-SMI) help in overcoming the most common barriers to mental health services, access, utilization, and appropriateness of care, which inhibit treatment engagement and positive treatment outcomes.

The research is innovative because it utilizes atypical or negative case analysis. Atypical case analysis focuses on data or participants who do not conform to expected outcomes or patterns (Creswell, 1998; Larrison, Schoppelrey, Hadley-Ives, & Ackerson, 2008). The atypical cases in this research are African American men who have had long-term positive experiences in rural outpatient psychiatric treatment for a serious mental illness. The study examined care from
the clients’ point of view and integrated their opinions about successful mental health care with information from key informants from the clients’ social support network. The choice to focus on clients located in rural communities introduces a significant geographic factor in our understanding of social support networks. The purpose of this research is to better understand the system interactions between clients, social supports, and mental health care agencies. The goal is to develop suggestions for positive actions mental health care providers can take to improve client engagement and outcomes.

This research utilized the network-episode model theoretical approach (Pescosolido & Boyer, 1999) to examine how the actions of social support networks (e.g. family, friends, fictive kin) motivate African American men to seek out and remain engaged in outpatient psychiatric services. Research has shown that expressions of social support and levels of social support differ across race and impact therapeutic outcomes for individuals experiencing a serious mental illness (Compton, Kaslow, & Walker, 2004; Rosenfarb, Bellack, & Aziz, 2006a). African American clients with support networks that demonstrated high levels of Expressed Emotions (EE), behavior typically identified by Caucasian families as “critical and intrusive”, showed better outcomes than African American clients with support networks which exhibited low levels of EE (Rosenfarb, Bellack, & Aziz, 2006b; Rosenfarb, Bellack, Aziz, Kratz, & Sayers, 2004). Better understanding the messages and actions of social support networks of African American men who successfully engage in treatment may provide insight into how providers and clients can surmount service barriers for this triply disadvantaged population.

Central to the project’s approach is the two stage sampling. The first stage is a purposeful sample of 26 African American men with serious mental illness who have successfully engaged in treatment. These men participated in semi-structured interviews about
their experiences in the mental health system and the role of social support in treatment engagement and outcomes. Snowball sampling was used to obtain the second stage of participants: Key informants from the men’s social support network who contributed significantly to the clients’ life and decision making process. From this list a second sample of 26 participants were interviewed. Thematic Analysis was used to code the transcribed interviews and identify themes about system actions and interactions.

This research builds knowledge about how client and social support networks overcome barriers to care and motivate engagement in outpatient psychiatric care. Findings from this research are used to frame recommendations for how mental health treatment providers can more successfully provide care to African American male clients and fully collaborate with social support networks.

**Research Questions**

The study has three specific research questions:

1) What client factors contribute to rural African American men with serious mental illness (AAM-SMI) engaging successfully in ongoing mental health treatment?

2) What social support factors contribute to rural AAM-SMI engaging successfully in ongoing mental health treatment?

3) How do race, gender, location, and social support contexts interact to influence treatment experiences?

**Significance**

This research has significant public health implications because it focuses exclusively on a highly vulnerable and underserved population: rural African American men with serious mental illnesses. “Studies of mental health help seeking behavior among rural families are rare,
even rarer are studies of African Americans living in these areas” (Murry, Heflinger, Suiter, & Brody, 2011, p. 1118). While African American mental health research has primarily focused on urban populations, studies have indicated that rural-urban location does impact African Americans’ mental health. Linn, Husaini, Whitten-Stovall, and Broomes (1989) compared levels of depression among African Americans in rural and urban settings. They found that urban and rural residents’ depression was influenced by different factors: Dissatisfaction with community support significantly impacted levels of depression among rural African Americans while negative life events were linked to depression among African American urban residents. Okwumabua, Baker, Wong, and Pilgrim (1997) compared social support networks of rural and urban African American elders. They found that rural African American elders reported higher levels of social support. Among elders with poor, “clinically isolated” social support, rural African American elders were less likely to experience depressive symptoms than urban African American elders (p. M244).

**Rural Location**

The participants in this sample live in 8 communities in Illinois and Kentucky that are classified as rural by the U.S. Census Bureau and Office of Management and Budget, i.e. having a population less than 50,000 people (Health Resources and Services Administration, n.d.). Approximately 5 million African Americans live in non-metropolitan rural areas (Probst, et al., 2002). Unfortunately, these rural areas are also the areas of the US most at risk of having limited mental health care options (Gustafson, Preston, & Hudson, 2009). The most common specialized mental health care service providers in these areas are community mental health agencies (CMHAs). All of the AAM-SMI participants in this study receive services from their local Community Mental Health Agency. The CMHAs are the main or even sole source of
specialized mental health care in the participants’ communities (Hartley, Bird, Lambert, & Coffin, 2002). This research will contribute greater knowledge about the barriers to mental health care for rural African Americans and the role of rural African American social support networks in motivating mental health treatment.

**Research Innovation**

The focus on a highly specific subpopulation who have been successful in long-term mental health care allows for greater control of several variables that have been shown to negatively affect mental health outcomes, ie. race, gender, and geographic location. This in turn should increase the reliability of identification of themes and variables that positively impact mental health outcomes (Boyatzis, 1998). This research will explore how social support impacts mental health outcomes for rural AAM-SMI but most importantly it will generate new theories as to how social support influences positive outcomes, ie. types of social support available, types of relationships that are influential, and key times for network intervention.

**Influence of Social Support**

Until the latter half of the twentieth century most social service agencies provided segregated services or did not serve African Americans (Grob, 1994). In response, the African American community developed their own parallel social support network, sometimes referred to as the Black helping tradition, to address common societal problems (Bentelspacher, Duncan, Collins, et al., 2006; Bullock, Crawford, & Tennstedt, 2003; Martin & Martin, 1985). The Black helping tradition placed immediate family at the center of a network which provided support and advice and that included “the extended family, the community, the African American churches, and the adoption of fictive kin” (Brown, 2008, p. 34). While there is evidence that the Black helping tradition’s role as primary social welfare system has declined as social service agencies
have become more integrated, the key Black community institutions (e.g. family, church) continue to serve as the initial source of support for community member experiencing mental illness (Blank, Mahmood, Fox, & Guterbock, 2002; Martin & Martin, 1985). For example, 70% of respondents in a sample of rural African American mothers stated that they would go to family first if their child had a mental illness (Murry, Heflinger, Suiter, & Brody, 2011).

The role of African American social support networks as informal primary mental health care make them important judges of and messengers about formal mental health services. Support networks have significant influence on individual’s choice to seek formal mental health care. Martinez and Lau (2010) found that the more satisfied African American parents were with the quality of their social support the less likely they were to use mental health services for their children. However, the importance of support networks does not end once an African American client has made the choice to seek formal mental health treatment. Social support network members continue to receive information from and transmit messages to clients as clients engage in mental health care (Pescosolido & Boyer, 1999). Therefore network members’ opinions of mental health care and providers could exacerbate client dissatisfaction or motivate clients to persist with care.

Despite the importance of social support networks and their influence over clients, research has indicated that support network members are largely ignored. Guarnaccia and Parra (1996) and Johnson (2000) provided insight into the experiences of African American families with a mentally ill family member. Caregivers complained that they felt discounted by the mental health treatment system. This was especially frustrating since African American families were more likely than White families to have their mentally ill family member living with them and to provide them with care such as cooking, cleaning, and shopping (Guarnaccia & Parra,
While caretakers felt they were very knowledgeable about their family member’s illness, symptoms, and needs, they did not feel that their input in treatment or service planning was wanted or used (Johnson, 2000). Mental health agencies who engender such negative feelings risk losing clients as support networks may fail to encourage individuals to continue with mental health care.

Barriers to Mental Health Care

This research is grounded in examining how social support networks in rural areas encourage clients to overcome three areas the Surgeon General identified as problems that negatively affect African Americans with mental illness: access to services, utilization of services, and appropriateness of services (DHHS, 2001). While the Surgeon General also identified availability of services as a concern in African American mental health care this topic is not a focus of this research because the participants all receive care.

Murry, Heflinger, Suiter, & Brody (2011) interviewed rural African Americans about barriers to mental health care: Participants were hesitant to utilize specialized mental health care because they were concerned about the cost of care (access) and expressed cultural mistrust of White mental health professionals (utilization). While many barriers to access, utilization, and appropriateness are well understood, little is known about how social support networks assist and motivate clients to overcome these obstacles. This research allows African American men and their social support network members to describe in their own words what issues they viewed as the greatest barriers, and most importantly, how they addressed and resolved these obstacles to achieve positive treatment outcomes.

Access. In general, access to mental health services is often limited by financial constraints and lack of payer source (DHHS, 2001). African American men are
disproportionately more likely to be among the working poor who have no insurance and mental health care benefits, whether provided privately by an employer or publicly through federal programs: “In 2005, men were 30 percent more likely to be uninsured for the previous year, as compared to women. Within that group, African American men were 75 percent more likely to be uninsured than White men” (Office of Minority Health, 2010, 8). In the interviews, data was collected about how participants pay for care and who assisted them in accessing public insurance options or other means to cover the cost of care. Interviews with social support network members also gauged network opinions of cost as a barrier to accessing mental health care and their knowledge of and involvement in payment issues.

Utilization. Willingness to utilize services can be inhibited by African American men’s mistrust of mental health providers. It is well documented that institutionalized racism and inequality persist in mental health care (Lowe, 2006): From 1950 to 2000, over 175 research studies documented evidence of racism in the American mental health care system (Ridley, 2005). While overt racism in mental health care settings has decreased, some argue that such behavior has simply been supplanted by microaggressions that subtly convey stereotypes or dismiss the racialized experiences of African Americans (Sue, Capoldilupo, & Holder, 2008). Client participants were asked to share details of their mental health care history, specifically when and why they chose to seek formal treatment, their experiences with mental health care providers, and if social support members influenced their decision to utilize services. Social support network member participants also described their interactions with agencies and their view of mental health treatment as outside observers of the system.

 Appropriateness. The Surgeon General’s report cited misdiagnosis as the primary barrier to appropriate care for African Americans (DHHS, 2001). African American men are
twice as likely to be diagnosed with schizophrenia as schizoaffective disorder and significantly more likely to be diagnosed with schizophrenia than similar White patients (DHHS, 2001). The over-diagnosis of schizophrenia among AAM-SMI is likely a result of misdiagnosis and under-diagnosis of bipolar disorder and major depressive disorder (Neighbors et al., 2003; Strakowski et al., 1996). Misdiagnosis is a serious concern as it results in ineffective treatment for African American men, particularly in regards to appropriate medication prescription (Barnes, 2008).

While mental health professionals understand the details of inappropriate treatment and diagnosis, lay people may only frame these issues as feeling that treatment did not help. Interviews gauged participants’ perceptions of appropriateness of care by collecting information from clients and their families about what interventions or services have been most and least helpful. Participants were also asked how CMHAs can better attract and serve African American men as clients and how participants understood the interplay between race and mental illness.

Dissertation Chapters

The literature review chapter examines African American men’s mental health from theoretical, historical, political, and treatment perspectives. Theoretical frameworks are discussed on the macro and mezzo level. At the societal level it discusses the involvement of social support networks in the black helping tradition or modification of hegemonic masculinity socialization via cool pose. On the mezzo level practice interventions including intersectionality, client-therapist matching, and multicultural counseling are presented. Policies affecting African American men’s mental health care from slavery to the Community Mental Health Centers Acts to the Affordable Care Act are reviewed.

The methods chapter explains the theoretical and methodological approaches used in this research, particularly Pescosolido and Boyer’s (1999) network-episode model. The author has a
postpositivist world view and used a semi-structured interview format to collect data from rural African American men with serious mental illness and members of their social support networks. Interviews were coded using thematic analysis. ELAN coding software was used to code the interviews.

In the results, findings from client participants and social support participants are presented. In addition, interviews with both clients and social supports are compared to identify similarities and differences in opinions. Thematic summary is used to provide an overview of the qualitative interview responses and narrative quotes are used to illustrate and support the reported results.

In the discussion the implications of key findings are presented and integrated with the existing literature. Suggestions are made for how CMHAs can better collaborate with client social support networks in order to increase satisfaction among clients and social support networks and build a positive reputation in the African American community.

In the final conclusion chapter the major study findings are summarized and directions for future research are presented.
CHAPTER 2

LITERATURE REVIEW

In Ralph Ellison’s (1952) novel *Invisible Man* the narrator is an African American man who recounts his life story. The narrator describes his experiences as he grew up in the 1930s and made his way from the South to Harlem. He became involved with many individuals, groups, and movements during his journey before realizing that few of them truly saw him as a person rather than a stereotype of Blackness, a tool to accomplish their own goals, or a non-entity. During a riot the narrator is chased into a coal cellar where, overwhelmed and angry, he decides to live underground and remove himself from society.

Ellison meant for *Invisible Man* to capture the emotions and struggles of being an African American man in 20th century America. However, the narrator’s story of invisibility, discrimination, empowerment, disillusionment and ultimately hope can also be seen in the course of mental health care for African American men in the United States. African American men have moved from a past where they were barred from formal mental health care systems to a future where equal care is a national priority. The change has not been a perfect upward trajectory but a process with false starts, steps forward, steps back, successes, and failures.

This chapter will focus on understanding the system factors that create and prevent disparities in mental health care for African American men. The first section will examine how societal and cultural norms in the United States and the African American community impact African American men and their views of mental health care. The second section will further explore macro level factors by considering how U.S. mental health care policy has reinforced or dismantled existing barriers to quality mental health care for African American men via guidelines, funding, and research choices. The third section will further explore mezzo system
factors by examining mental health therapies and interventions that frame treatment and provider relationship within the experiences and system environments of African American men.

**Macro and Mezzo Understanding of African American Men and Mental Illness**

The 2001 Surgeon General supplemental report and the 2002 Institute of Medicine report affirmed that African Americans have less access to mental health care, are less likely to receive care, receive poorer quality care, and are underrepresented in mental health research (DHHS, 2001; IOM, 2002). When compared to African American men without mental illness or men with mental illness receiving appropriate care, undiagnosed, untreated, or incorrectly treated mental illness has been linked directly and indirectly to increased morbidity and mortality in African American men due to higher rates of substance abuse, homelessness, untreated medical conditions, and suicide (DHHS, 2001). It has been theorized that hesitation among African American men to seek formal mental health treatment may be linked to mistrust of mental health providers due to historic experiences of racism, ongoing microaggressions in therapeutic interactions, and pressure associated with perceived gender roles (Wade, 2008; Williams & Williams-Morris, 2000).

Problems associated with mental health care negatively affect not only African American male clients but also their caregivers and support systems. Guarnaccia and Parra (1996) and Johnson (2000) provided insight into the experiences of African American families with a mentally ill family member. Caregivers complained that they felt discounted by the mental health treatment system. While caretakers felt they were very knowledgeable about their family member’s illness, symptoms, and needs, they did not feel that their input in treatment or service planning was wanted or used.
Impact of Racism on Diagnosis and Treatment Disparities

The intent of the Diagnostic and Statistical Manual of Mental Disorders is to provide a framework for diagnosis that can be applied consistently. However, the American Psychiatric Association (2000) acknowledges that categorical classification is an imperfect approach that is impacted by the heterogeneity of clinicians and clients. Recent research has raised the concern that diagnosis, and subsequent treatment, of African American men continues to be clouded by racism (Eack, Bahorik, Newhill, Neighbors, & Davis, 2012). This is not to say that mental health providers are racist or actively working against the best interests of their clients: Sue, Capoldilupo, and Holder (2008) assert that overt racism in mental health care settings has decreased but that such behavior has been supplanted by sometimes unconscious microaggressions that subtly convey stereotypes or dismiss the racialized experiences of Black Americans.

There is valid support for the fear that microagression, institutionalized racism and inequality persist in mental health care (Ridley, 2005). There are limited findings about African American men as a specific group but the minimal existing research has established evidence of the disparities experienced by African American men. For example, African American men are less likely than Whites to receive care that follows recommended treatment guidelines (Young, Klap, Sherbourne, & Wells, 2001) and more likely to receive unusually high doses of psychotropic medications when compared with individuals from other racial groups who had similar diagnoses (Lawson & Strickland, 2004).

African American men are also twice as likely to be diagnosed with schizophrenia as schizoaffective disorder and significantly more likely to be diagnosed with schizophrenia than similar White patients (DHHS, 2001). The over-diagnosis of schizophrenia among African American
American men with serious mental illness is likely a result of misdiagnosis and under-diagnosis of bipolar disorder and major depressive disorder (Neighbors, Trierweiler, Ford, & Muroff, 2003; Strakowski et al., 1996). Anglin and Malaspina (2008) examined not only rates of diagnosis but also the pattern of diagnostic change over time at an inpatient facility. They found that while “the frequency of diagnostic change was not statistically different between racial/ethnic groups…different types of diagnostic changes occurred for the different racial/ethnic groups” (p. 467). Between admission and discharge, African Americans were most likely to see their diagnosis altered from undifferentiated schizophrenia or psychotic disorder to paranoid schizophrenia, while Whites were most likely to move from paranoid schizophrenia to either schizoaffective disorder or undifferentiated schizophrenia.

Research findings to date indicate that our understanding of racially linked disparities in mental health care will have to take into account the complex factors of contemporary racism and mental health care. Researching and addressing the impact of racism on African American men’s mental health care experiences will require in-depth analysis of how clients, clinicians, and organizations interact and amplify or diminish disparities.

**African American Men and Masculinity**

Stereotypical gender identification has been proven to be negatively linked to help-seeking behaviors and mental and physical health outcomes among men, irrespective of race (Courtenay, 2000; Wade, 2008). Men are less likely than women to seek professional medical care and ask less questions when they do see medical providers (Addis & Mahalik, 2003). Scott, Munson, McMillen, & Snowden (2007) studied a group of high-risk African American young men to determine what factors impacted their likelihood of accessing mental health services.
They found a significant negative correlation between youths’ propensity to seek mental health care and their level of adherence to stereotypical masculine norms such as emotional restraint.

Even if men, their family members, or health care providers are attentive to signs of depression or mental illness, symptoms may be obscured by more prominent negative behaviors. While women are more likely to be diagnosed with anxiety, depression, or eating disorders, men are more likely to be diagnosed with alcohol or illegal substance abuse/dependence and antisocial personality disorder (American Psychiatric Association, 2000; Brooks, 2001).

There is no biological evidence supporting differences in the rates of mental illness between genders; however, women throughout the world are more likely to seek mental health care than men (WHO, 2009). This gap is believed to be the result of differences in gender role socialization rather than a function of innate differences between the sexes (Addis & Mahalik, 2003). Men in the United States are generally socialized to conform to “hegemonic masculinity”, a gender role that defines men as physically and emotionally tough. Men are encouraged to present themselves as independent and self-reliant, to cultivate competitive and power-seeking behaviors, and avoid overt expressions of vulnerability or emotions (Connell, 1987). Majors and Bilson (1992) hypothesized that African American men have developed their own strain of hegemonic masculine identity, which the authors described as cool pose. This form of hegemonic masculinity was formed as a coping mechanism for living in an overtly and covertly hostile environment. African American men engaging in cool pose use body language, facial expressions, and speech to project the appearance of stoicism and disinterest that masks emotional reactions to racial antagonism and microaggressions. While this masculine identity can serve as a protective factor for African American men it also encourages them to distance themselves from their emotions and discourages them from processing their feelings openly.
The result is that African American men may be less likely to engage in formal mental health interventions (Aymer, 2010). In his book on Black men and depression John Head (2004) discussed his gender identity socialization growing up in the African American community and its later impact on his own battles with depression. His description of how the ideal man was presented to him reflects the norms espoused in cool pose,

These men kept their emotions under control and to themselves. That was one of the reasons they were admired in the community. They stood in contrast to the men whose emotions were on public display. Those were the men who let loose their anger, sometimes acting out in violence. They were the men I was warned against emulating. Someone who kept his emotions restrained – except in church – was the type of man I was told I should grow up to be (p. 37).

Men who identify strongly with hegemonic masculinity may, consciously or unconsciously, not feel societally sanctioned to express distress. Instead they are more likely to express depression and anxiety through somatic complaints or expressions of anger and violence and may use illegal substances and alcohol as self-medicating techniques to deal with stress (Addis & Mahalik, 2003; Brownhill, Wilhelm, Barlay, & Parker, 2002; Connor et al., 2010). Brown, Schulberg, and Madonia (1996) found that in a sample of primary care patients experiencing major depression, African American men were twice as likely as White men to have a history of alcohol dependence. The social, occupational, medical, and even legal consequences of violent behavior and alcohol and substance abuse mean that these symptoms are targeted for treatment first and the underlying mental health issues may be neglected.
Social Support and the Black Helping Tradition

People facing the difficulties associated with serious mental illness frequently turn to their loved ones for support and guidance (Topor, Borg, Di Girolamo, & Davidson, 2011). In addition, reliance on family and community among African Americans was necessitated for most of the United States’ history because social services segregated White and African American clients or simply refused to serve African Americans (Grob, 1994). The African American community developed their own parallel social support system, sometimes referred to as the Black helping tradition, to address common societal problems (Bentelspacher, Duncan, Collins, et al., 2006; Bullock, Crawford, & Tennstedt, 2003; Martin & Martin, 1985). The black helping tradition placed immediate family at the center of a network that included “the extended family, the community, the African American churches, and the adoption of fictive kin” (Brown, 2008, p. 34) and which provided support and advice. While there is evidence that the black helping tradition’s role as primary social welfare system has declined as social service agencies have become more integrated, the key Black community institutions (e.g. family, church) continue to play a vital role in shaping Black American views of mental illness and influencing mental health care interactions (Blank, Mahmood, Fox, & Guterbock, 2002; Martin & Martin, 1985).

Research focusing on African American families has suggested that the support and involvement of family has an even greater impact on African American men experiencing mental health issues than on members of other racial/ethnic groups. Lindsey, Joe, and Nebbit (2010) found that African American boys experiencing depression did not trust peers or mental health providers but relied on family as their primary support and first recourse for mental health care and advice. Guada, Brekke, Floyd, and Barbour (2009) examined the family relationships of people with schizophrenia. They found that African American men had less family contact than
African American women, yet they had more frequent family contact than a sample of similar White participants. The greater family contact was linked to increased psychosocial functioning. In a similar study, Rosenfarb, Bellack, and Aziz (2006b) documented the levels of Expressed Emotion (EE) among White and African American families. While high levels of EE are often characterized as intrusive or critical and are linked to increased symptomology in White patients, Rosenfarb et al. found that African American men benefited from high EE from family members and likely perceived this involvement as evidence of caring and concern.

In addition to the recognizing the important role of family in the mental health trajectories of African American men, research suggests that rates of mental health service use could be improved if practitioners utilized already existing support systems such as the Black church (Blank, Mahmood, Fox, & Guterbock, 2002; LaFromboise, Timble, & Mohatt, 1990). The Black church may be an especially useful support system for African American men as the church has historically served as a place where African American men could regain their roles as respected family and community leaders away from the negative encounters of everyday American society (Adksion-Bradley, Johnson, Sanders, Duncan, & Holcomb-McCoy, 2005; Johnson, 2010). Blank et al. (2002) found that Black churches offered parishioners significantly more social support and counseling services than White churches but typically did not have formal relationships with health or mental health agencies. Mattis et al. (2007) found that even when African American parishioners were not comfortable approaching their church leader with problems such as mental illness or substance abuse issues they still cited other members of the church as sources of support and information.

**Mental Health Policy and African American Men**

Macro level factors that influence mental health care and African American men are not
simply an accident of history. The mental health care system is constantly influenced by the U.S. government’s ongoing policy choices regarding laws, programs, and funding. Unfortunately, a specific focus on the well-being of African American men has been absent from planning and program implementation in U.S. mental health care policy and funding. Social programs designed to meet basic needs such as food, housing, and payment for care, needs that must be addressed before mental health interventions can be successfully applied, rarely provide services to African American men.

Despite a historic dearth of attention and services, at the beginning of the 21st century US policy began to shift. Publications such as the Surgeon General’s *Mental Health: Culture, Race, and Ethnicity* and changes in federal funding allocations for research have indicated that the federal government has begun to focus more on the mental health needs of people of color. This section will provide a historical overview of US mental health policy in regards to African American men and discuss current policy changes and future directions.

A Legacy of Neglect

Black people were brought to North America to serve as slaves for roughly 300 years from the 1500s until 1865 when slavery was abolished by the 13th amendment (Miller, 2001). Because slaves were considered property, their care was the responsibility of the slave master. As a result, the European colonizing nations or subsequent U.S. government did not have to provide to African Americans the social services that are typically afforded to citizens. At the end of the Civil War in 1865, the United States realized it would soon be responsible for roughly 4 million newly freed slaves who had nowhere to live and no employment to support them. In response, congress created the Bureau of Refugees, Freedmen, and Abandoned Lands, typically
called the Freedmen’s Bureau. The Bureau operated under the auspices of the War Department (Karger & Stoesz, 2010).

The Freedman’s Bureau operated between 1865 and 1872, initially providing emergency relief and later offering or funding programs to help freed slaves find homes, work, education, and medical and mental health care (Karger & Stoesz, 2010). While Bureau officials provided general explanations in their reports about aid provided to African American women and children they took care to note the low numbers of African American men on the roles and to explain why each was deserving of aid due to being elderly, disabled, blind, mentally ill, etc. (Farmer-Kaiser, 2007). Rabinowitz (1974) notes that the Freedmen’s Bureau unintentionally helped put policies in place that negatively shaped later social welfare policy for African American men by framing African American men as unworthy recipients of social services. Additionally, the availability of Freedman’s Bureau resources was manipulated as an opportunity to create the segregated system that persisted in the South long after the civil war. The direct impact on mental health services was that during Reconstruction state and municipal governments agreed to provide services and build asylums for their own White poor and infirm but insisted that the Blacks be cared for with federal funds in separate facilities.

By the 1830s the US was moving toward mental health care in county and state asylums (Trattner, 1999). The state asylums, run and paid for by state government, became the first significant, organized, and centralized mental health care system in the United States and quickly supplanted county facilities (Trattner, 1999). The insane asylums, later called state hospitals, were tasked with serving mentally ill citizens in specific geographic areas of each state. The asylums were residential facilities where patients lived and received the recommended mental health treatments of the era. State and local governments were free to set local policy for African
Americans. Most asylums either chose not to serve African Americans or kept patients segregated by race. Even at institutions that segregated care the accommodations and services provided to African American patients were far inferior to the care for Whites due to substandard housing, overcrowding, and reduced staff (Grob, 1994). Further, state and asylum administrators often determined who would receive services, regardless of patient wishes and African American men were consistently more likely than White men to be committed to asylums against their will (Davis, Lewis, Zhang, & Thompkins, 2011).

Exclusion, segregation, and disparities in involuntary commitments continued mostly unchanged well into the 1900s (Davis, Lewis, Zhang, & Thompkins, 2011; Trattner, 1999). Though African American activists tried to engage state and federal governments in the provision of care for African Americans these efforts were largely unsuccessful. In the end, African American communities were forced to turn inward, as they had in the past, and provide care for their own. African American families, churches, and social groups provided emotional and tangible support for people with mental illness and their caregivers. They also raised money for private care and established institutions for African American patients (Lowe, 2006; Martin & Martin, 1985).

The Modern Era of Mental Health Care

World War II became a turning point in the provision of mental health care in America. During the war the largest single reason men were rejected for military service were mental disorders (Trattner, 1999, p. 206). In addition, many soldiers, including Black service members, returned from combat suffering from “battle fatigue”, what is now called Post Traumatic Stress Disorder (PTSD). In response, the United States congress passed the National Mental Health Act of 1946. The National Mental Health Act established the National Institute of Mental Health
and provided funding for the first comprehensive report on the mental health needs in the United States. The report, *Action for Mental Health*, was released in 1961 into an environment ripe for change. Exposés of the inhumane conditions in asylums had soured the country on institutional care and advances in psychotropic medication offered hope for medically based cures of mental illness. *Action for Mental Health* recommended a new, community based, outpatient approach to providing mental health care (Karger & Stoesz, 2010; Trattner, 1999). This was a significant break from the long-standing asylum model.

**Community Mental Health Centers Acts of 1963 and 1965.** The Community Mental Health Centers Acts of 1963 and 1965 (CMHC Acts) created community centers that would provide mental health services to the residents of geographic catchment areas: From 1963-1980 the federal government built 789 community mental health centers throughout the U.S. (Torrey, 2013). At the same time as the CMHC Acts the Civil Rights Act of 1964 outlawed discrimination and racial segregation in health and mental health care settings that receive federal funds to support services. This confluence of policy and development should have resulted in reliably accessible mental health care and treatment for Black Americans (Neighbors, 1989). However, despite the lofty goals of the CMHC Acts the community mental health centers were never given the necessary funding from federal or state governments to open enough mental health centers and provide the full continuum of care with which they had originally been tasked. Once again mental health care was a sparse commodity that was not readily available to poor and middle class Americans (Trattner, 1999). Disillusioned by the negative repercussions of deinstitutionalization and the failure to fully realize the dream of community mental health centers, U.S. mental health care entered the fourth cycle of reform in the early 1980s (Goldman & Morrisey, 1985). Community mental health centers began to move away from the idea of a
self-contained center that provided the full-spectrum of mental health care and toward a new identity as community mental health agencies (CMHAs) that were leaders of “community support systems, a broad network of mental health and social welfare services for care of the chronically mentally ill in noninstituional settings” (Goldman & Morrisey, 1985p. 727).

**Medicaid.** Today the dominate way that people with mental illnesses can insure access to care at community mental health centers is to have a guaranteed payer source such as private health insurance or Medicaid. In fact, Medicaid has become the largest public funding source for community mental health care in the United States, surpassing the combined funding of state general funds and federal block grants (Lutterman, 2011). In 2005 Medicaid and Medicare spent over $60 billion on mental health care services (Torrey, 2013). The reliance on Medicaid as a funding source began soon after the passage of Medicare and Medicaid in 1965. Medicaid offered care and treatment funding for eligible mental health clients who were moved out of state run asylums. States saw this as an opportunity to shift some of the financial burden of care to the federal budget and began pursuing Medicaid as the preferred payer source for low-income mental health clients (Grob, 2005).

While state and block grant funding is allocated for CMHCs to provide mental health care to residents in their service area, Medicaid only pays for people who meet specific eligibility requirements and have been enrolled in the program. This shift in funding streams has created additional access problems for African American men without health insurance. Community mental health centers have incentives to pursue clients who are Medicaid eligible but Medicaid is only mandated to cover specific groups that are generally comprised of children who meet detailed poverty guidelines, their parent/guardian, and certain disabled people (Centers for Medicaid & Medicare Services, 2005). African American men are less likely to qualify for
Medicaid as primary caregivers since in 2011 only 22% of African American families in poverty were headed by married couples or single fathers (U.S. Census, n.d.a). The other path to Medicaid for African American men is to make it through the long and complicated disability process, which has been plagued with delays and multiple appeals (Randazzo, 2012; Social Security Administration, 2007). Overall, African American men are disproportionately more likely to be among the working poor who have no insurance or mental health care benefits, whether provided privately by an employer or publicly through federal programs: “In 2005, men were 30 percent more likely to be uninsured for the previous year, as compared to women. Within that group, African American men were 75 percent more likely to be uninsured than White men” (Office of Minority Health, 2010, 8).

**Surgeon General’s Reports.** In 1999 the US Surgeon General, in collaboration with the National Institutes of Health (NIH) and the Substance Abuse and Mental Health Services Administration (SAMHSA), released *Mental Health: A Report of the Surgeon General.* The goal of the report was to summarize current knowledge about mental illness, encourage treatment, destigmatize mental health issues, and advocate an integrated view of mental and physical health (DHHS, 1999). The 1999 report contained some information about disparities but this issue was given much fuller treatment two years later in *Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General.* The supplemental report focused on four racial and ethnic minorities: African Americans, American Indians, Asian Americans, and Hispanic Americans. The goals of the supplement were to document racial and ethnic disparities in mental health care and explore possible interventions to address disparities and promote positive mental health. The report presented evidence that African Americans experienced specific barriers and disparities in the basic availability of
mental health services, the ability to access available care, and the quality and range of services provided (DHHS, 2001).

Davis (2003) observed that though it was not a stated goal of the supplemental report, one of the benefits was that it helped address decades of incorrect stereotypes and assumptions about race and mental illness, such as the belief that African Americans are more prone to mental illness, an assumption that may have contributed to over-diagnosis of serious mental illnesses among African American men. While this was a good start, the report could not undo centuries of bias in mental health care so the Surgeon General recommended an increase in scientific research focused on understanding factors that impact minority mental health care and confirm the efficacy of clinical interventions with minority groups. Additionally the report recommended that steps be taken to improve access, reduce barriers, improve the quality of treatment, and increase the number of mental health providers with culturally competent counseling skills (DHHS, 2001).

While this report was a high point in US policy focus on the mental health needs of African Americans, Davis (2003) raised the question of how the federal government intended to encourage or assure these changes without funding or specific policies from the federal government that address long-term discrimination and apathy in the social safety net. A decade after Mental Health: Culture, Race, and Ethnicity there are only a limited number of targeted efforts to encourage the report’s recommendations, mostly aimed at increased funding for mental health research with minorities. No large scale efforts to change the mental health care system in the United States have occurred. Instead of waiting for the federal government, Davis (2003) encourages social workers and other mental health professionals to take the initiative and address barriers and disparities within their own agencies and practice.
The Patient Protection and Affordable Care Act. Passed in 2010, the Patient Protection and Affordable Care Act (ACA), sometimes called healthcare reform, offers a combination of new regulations, tax credits, and insurance options with the aim of decreasing health insurance costs and increasing the number of Americans with health insurance (DHHS, 2010a). The hope is that up to 32 million more Americans will be covered by health insurance by 2014 through a number of changes to private insurance, Medicaid, and Medicare (DHHS, 2010a). The National Healthcare Disparities Report identified greater insurance coverage as one of the key steps toward reducing health disparities between White and minority communities (Agency for Health Care Research and Quality, 2003). The expansion of coverage is especially needed by African American men since the U.S. Census Bureau (2010) estimates that 30% of African American men, over 4 million men, are without insurance coverage.

The ACA addresses mental health care disparities by insuring access to preventative and early intervention care and increasing mental health benefits and parity. ACA requires health insurance, depending on the plan, to cover all or most of the cost of specific preventive care such as screenings for depression and alcohol abuse (DHHS, 2010b). ACA expanded the scope of the Mental Health Parity and Addiction Equity Act of 2008 by requiring all plans in the Insurance Exchanges to offer mental health and substance abuse services comparable to medical benefits (APA Practice Organization, 2011) and as of 2014 it will make it illegal to deny insurance based on pre-existing substance abuse or mental health conditions (Hyde, 2010).

ACA also influenced how future research on minority behavioral and physical health will be funded. ACA promoted the National Center on Minority Health and Health Disparities (NCMHD) to the National Institute on Minority Health and Health Disparities (NIMHD) at the National Institutes of Health (NIH). The transition from Center to Institute gave the NIMHD “a
more defined role in the NIH's research agenda” and expands the scope of the NIMHD Research Endowment program (NIH, 2010, 1). In regards to mental health the NIMHD is focused on recruiting and training more minority researchers and increasing understanding the unique mental health needs of minority groups (NIMHD, n.d.). One example of such work in the African American community is NIMHD collaboration with community organizations, researchers, and other NIH institutes to understand the impact of Hurricanes Katrina and Rita on mental health service systems and long term mental health outcomes in the southeast US (NIMHD, n.d.). The creation of a minority health focused institute will help ensure that calls for increased research investigating and addressing African American men’s mental health disparities will become a reality instead of remaining a well-meaning goal.

**Mental Health Practice Theories and Interventions with African American Men**

In an effort to address treatment disparities mental health providers have worked to increase awareness of the multi-system risk factors that affect African American men and develop practice theories as well as interventions that incorporate multicultural approaches. There has been an increased focus in education on multiculturalism, diversity, and White privilege; the accrediting bodies for psychiatry, psychology, and social work all require educational programs to demonstrate how they train students to be aware and respectful of cultural diversity (Accreditation Council for Graduate Medical Education, 2008; American Psychiatric Association, 2009; Council on Social Work Education, 2008). Some theorists have proposed race/ethnicity/cultural-centric therapeutic models as a means to provide appropriate care. This section will discuss three contemporary practice approaches that have been proposed as models to combat disparities in mental health care and outcomes for African American men.
**Intersectionality Theory**

Intersectionality theory states that people possess multiple identities predicated on factors such as their gender, class, physical ability, or religion. These identities interact and overlap to influence individuals’ experiences of their identity (Samuels & Ross-Sheriff, 2008). For African American men the racialized history of the United States and the African American communities lived experiences impact men’s understanding of their individual identities.

Recent research has examined the intersection of African American racial identity, masculine gender identity, and sexual orientation identity to provide illuminating discussions of the experiences of African American men. While being Black is a disadvantaged racial identity in the United States, this effect is heightened when masculine gender identity is incorporated. Originating in slavery stereotypes and continuing to present day, Black men have been characterized as dangerous and prone to violence and crime. Modern social science research and fictional portrayals have added to the stereotype by characterizing Black men as immature and irresponsible fathers and family providers (Chaney, 2009; Connor, 2002). Dottolo and Steward (2008) interviewed middle-age Black and White participants about their racial identities. The majority of Black participants shared stories of discrimination and racial profiling but they specifically stressed concern for young male family members, who are routinely targets of police attention. One Black woman recounted preparing her son for the discrimination he would encounter, “‘Don’t ever forget now, you’re a Black man in America. Now don’t just go out here and go crazy - You’re a Black man in America” (p. 356).

In examining mental health care disparities, African American psychology scholars argue that mental health care systems are rooted in the experiences of the dominant, White cultural understanding of race and thus take a color-blind approach to mental health interventions.
African American men who seek mental health care are often confronted with therapists who do not understand the clients’ developmental and environmental issues or the weight of their status as a black man in America (Johnson, 2010). A number of mental health researchers have suggested ways that practitioners can treat African American men, as individuals or parts of family units, with an intersectionality lens or by integrating identity and intersectionality into additional practice modalities in order to more fully acknowledge and address the environmental and social issues affecting African American male clients (Boyd-Franklin, 2003; Jackson, 1992; Johnson, 2010; Logan, Freeman, & McRoy, 1990; Connor, 2002; Rasheed & Rasheed, 1990).

Tyler, Brome, and Williams’s (1991) ethnic validity model provides a useful caveat to race based mental health theories. They note that interventions that are reliant on racial/ethnic identity are only effective for clients who have strong or positive ethnic group identification. An African American man who has negative feelings toward his group membership, who assigns master status to another aspect of his identity, or who simply does not see the relevance of race to the issue for which he is seeking assistance may experience conflict with a therapist applying a culturally grounded intervention. As always, mental health care must be tailored to the individual client and meet the client where they are when addressing issues of race.

**Client-Therapist Racial Matching**

In an attempt to address race and ethnicity based misinterpretation or ignorance in mental health care some researchers have suggested pairing therapists and clients based on race and ethnicity. Debate quickly arose about whether mental health therapy was delivered the same regardless of race or if cross-racial therapeutic dyads were at the root of treatment disparities. In 1988 Stanley Sue reviewed the previous two decades of available literature on client-therapist
ethnic matching. He found limited empirical studies, pervasive methodological limitations, and conflicting results that made it difficult to support an opinion on the benefit of client-therapist racial matching.

In the subsequent decade researchers explored the impact of client-therapist racial matching in mental health care. Chinman, Rosenheck, & Lam (2000) examined case manager-client matching in a program for people who were homeless and severely mentally ill. While they did confirm that there were outcome disparities, “White clients had greater reduction in psychotic symptoms than did African American clients” (p. 1265), there was no link between racial matching and client outcomes or service use. Maramba and Hall (2002) conducted a meta-analysis of seven ethnic matching studies conducted in the 1990s. Their analysis found that neither like-ethnic matching or different-ethnic matching affected client functioning, drop out rates, or length of time in treatment. Shin et al. (2005) conducted a similar meta-analysis of ten studies comparing only African American and White client-therapist matching. Again, the analysis revealed that matching was not a predictor of client retention or functioning.

The most likely explanation for the lack of evidence supporting client-therapist matching is that race and gender identity are not direct correlates for culture and worldview. Simply because a client and therapist are both African American men does not mean that they will automatically share an array of similar attitudes and values. Tyrrell, Dozier, Teague, and Fallot (1999) examined a diverse group of clients with serious mental illness and their case managers. They found that race and gender were not predictors of “effectiveness of therapeutic relationships and client functioning” but rather the significant matching elements that translated to positive outcomes were “interpersonal and emotional strategies”, such as desired emotional closeness in the therapeutic relationship (p. 725). Furthermore, not every African American
male client wishes to be paired with a same race or gender provider. Townes, Chavez-Kohl, and Cunningham (2009) collected data from 168 African Americans about racial identity, help seeking behaviors, and preference for Black counselor in a variety of mental health scenarios. They found that there were significant in-group differences and “high levels of cultural mistrust, low assimilation attitudes, and high Afrocentric attitudes significantly predicted preference for a Black counselor” (p. 335).

**Multicultural Counseling**

Multicultural counseling shares the same assumptions as many of the previously discussed practice theories: Race and ethnicity are bound closely with identity and personal experience; neither member of the therapeutic dyad can abandon their identities and life experiences in the counseling session; and differing therapist and client racial, ethnic, and cultural identities can result in misinterpretations and miscommunications. However, multicultural counseling theory distinguishes itself in three key assertions. First, it stresses that the similarities between groups and identities are equally important as the differences. Second, in contrast to approaches such as client-therapist matching, multicultural counseling asserts that cross-cultural counseling competency can be learned and applied in order to prevent treatment inequalities (Pederson, 2000). Finally, it recognizes the intersectional nature of identities and focuses on an overall cultural, rather than purely racial, understanding.

Rasheed and Rasheed (1999) argue that counseling professions have applied a “negative invisibility” to African American men, placing them on the periphery of mental health therapy, programs, and policies and discounting them from the functioning of the African American family (p. 6). In order to combat this negative invisibility Thorn and Sarata (1998) reviewed counseling literature regarding African American male clients and recommended the use of
multicultural counseling strategies. They suggest that clinicians conduct a thorough self-analysis in order to understand their own world views and reactions to African American men as clients and educate themselves on African American culture and the societal dynamics impacting African American men.

Thorn and Sarata’s recommendations represent the application of Sue et al.’s (1982) three stages in the process of becoming culturally competent: being culturally aware; gaining cultural knowledge; and utilizing culturally competent skills in counseling. Being culturally aware requires the clinician to become aware of their own intersectional identities and how their socialization and education has influenced their beliefs and normative views (Pederson, 2000). For White clinicians this includes confronting White privilege, or how the disadvantaging of people of color benefits White people (McIntosh, 1990). Once the clinician has gained a significant level of cultural self-awareness they can begin gathering knowledge about other cultures.

Multicultural knowledge training can be executed through individual research or group activities as part of practitioner education or organizational diversity training. Carter-Black (2007) encourages the use of personal storytelling, an activity common in all cultures, to facilitate cross-cultural knowledge sharing between students training for careers as practitioners. This activity stresses the key assertion of multicultural counseling, that all peoples have similarities that they can mutually relate to and differences that can be learned and respected. Multicultural counseling competency is not accomplished when additional knowledge and awareness has been achieved. Practitioners must alter the way they provide services. Pederson (2000) suggests the use of alternative or complementary therapies, i.e. therapies that do not reflect conventional Western values and assumptions, to provide culturally competent care.
Therapists can seek consultation with alternative support systems or indigenous practitioners to provide interventions in conjunction with Western therapies. For African American men this might mean, if agreeable to the client, collaboration with family, fictive kin, or church organizations. Another way to provide multicultural competent care is for practitioners to integrate additional mental health theories such as African American Psychology or complementary therapies with their standard treatment modalities (DHHS, 2001).

Studies have revealed that multicultural counseling does have two consistent weaknesses. Evaluations of multicultural counseling training have found that often these programs leave practitioners feeling that they have high levels of awareness but still lack the knowledge and skills necessary to implement multicultural interventions (Pederson, 2000). In addition, in studies where mental health providers are asked to rate their own level of cultural competence during therapy compared with an observer’s rating of the same therapists, the counselors’ self-ratings of skill are inflated compared to observer evaluations (Cartwright, Daniels, Zhang, 2008). As a result, the effectiveness of multicultural counseling strategies can be minimized: In an analysis of organization, therapist, and client variables at community mental health centers Larrison, Schoppelrey, Hack-Ritzo, and Korr (2011) found that multicultural counseling skill, awareness, and sensitivity did not minimize racial disparities.

**Conclusion**

At the end of Ellison’s novel the narrator of *Invisible Man* is still in “hibernation” underground. After thinking about his life and how his experiences have shaped him he realizes his reexamination has caused him to view himself and his purpose in life differently. The narrator finally decides he is ready to resurface from his underground hiding place to return to society and attempt to define himself on his own terms.
Similar to Invisible Man, mental health care for African American men has grown, developed, and is coming into its own. Theoretical and practice models take into account how society, culture, family, and individual personality interact to shape African American men and their attitudes toward the mental health care system. Now the opportunity has emerged to change not just our theoretical understanding of mental health care but our responses and interventions. The research evidence is clear that mezzo and macro systems influence African American men and that mezzo level support systems such as extended family, friends, and the Black church contribute to positive mental health outcomes for African American men. The next step in developing targeted mental health care is to fully utilize these existing systems and protective factors inherent in social support networks of African American men. African American communities and churches should be approached as key opinion makers who can be sources of referrals for men needing mental health care. Once men have entered care, providers should explore who offers the client nurturant and problem-solving support and whether the client is willing to allow their social support network members access to information about his treatment. Further research is needed to understand how social networks influence choices to seek and remain in care. Inclusion of key social supports in understanding mental health diagnoses, treatment approaches, and expected outcomes will likely result in a more positive community attitudes toward mental health care and a more supportive and coordinated relationship between in-clinic and out-of-clinic environments. Recognition of the formative impact of mezzo and macro level factors will not be complete until these systems are incorporated into treatment.
CHAPTER 3

METHODS

Preliminary Studies

This study is based in the NIMH funded research project Climate, Diversity and Outcomes in Rural Mental Health which aimed to “further our understanding of the relative contributions of organizational-, staff-, and client-level factors to disparities in outcomes among African American clients receiving services at Community Mental Health Agencies” (Larrison, Schoppelrey, & Ackerson, 2006, p. 30). The project included approximately 300 staff and longitudinal data from more than 800 clients at 13 sites throughout Illinois and Kentucky. To date, findings from this research reflect the importance of the proposed project. Some factors that are currently thought to influence disparities, including a clinician’s race and multicultural counseling competency skills, knowledge, and awareness, did not affect the occurrence of outcome disparities. The only factor associated with the occurrence of disparities was the number of positive relationships clinicians formed with people from other racial and ethnic groups (Larrison, Schoppelrey, Hack-Ritzo, & Korr, 2011). The data also indicated that some CMHAs’ organizational climates were linked to disparities (Larrison, Schoppelrey, & Hack-Ritzo, 2009). Further analysis of outcome disparities between White clients and Black clients revealed that clinicians accounted for 28.7 percent of the variability in outcomes and agencies accounted for 21.7 percent of the variability (Larrison & Schoppelrey, 2011; Larrison, Schoppelrey, & Hack-Ritzo, 2011). With 49.6 percent of variability in outcomes not accounted for this means that factors outside the organizational environments and staff can serve as mediating factors in treatment experiences and outcomes. Successful AAM-SMI clients exist at CMHAs that are both successful and unsuccessful with minority patients: Learning more about
African American men who have stayed in treatment at both types of agencies may help to identify factors in the social support network that are common to successful treatment.

Data from African American and White male participants from Climate, Diversity, and Outcomes in Rural Mental Health were compared to assess intergroup differences. Fifty-five percent of African American men were still regularly receiving services at the third research assessment, a rate six percentage points lower than White men. Analysis also revealed that approximately 40% of the White men (N = 192) were diagnosed with schizophrenia or related psychotic disorders, 13.5% with bipolar disorder, and 29% with major depressive disorder or other mood disorders. Among African American men (N = 76), approximately 61% were diagnosed with schizophrenia or related psychotic disorders, 4% with bipolar disorder, and 17% with major depression or other mood disorders. Despite these incongruities in diagnoses, differences in symptom severity or presentation were not reflected in the longitudinal measures of functioning collected using the Behavior and Symptom Identification Scale (BASIS 24; Eisen, Dill, & Grob, 1994). There was no statistically significant difference in the average BASIS scores over three measures for White men (1.36, 1.29, and 1.37) compared to African American men (1.29, 1.29, and 1.30).

African American men who left treatment (N=35) and those who stayed (N=41) were compared across numerous variables using SPSS software to conduct independent t-test, crosstab chi-squared, and Fisher’s exact test. No statistically significant differences were identified between the two groups when comparing diagnosis, BASIS scores over three measures, payment source, medication use, work or volunteer activities, age, evaluation of provider cross-cultural skills, and satisfaction with services. However, differences were identified between types of social support available to the clients. African American men who stayed in treatment were
more likely than AAM-SMI who left treatment to report that they had family support (p=.09). Those that left were more likely to report they had either spousal support (p=.09) or no social support at all (p=.10).

**Paradigm**

This study uses a postpositivist research paradigm. Postpositivism asserts that “there is an external, objective reality, but [researchers] are sensitive to the complexity of this reality and to the limitation of the researchers who study it and, in particular for social workers, the biases they bring to the study of social beings like themselves” (Engel & Schutt, 2009, p. 55). Working within this paradigm this research assumes that by interviewing participants we can better understand and describe the reality of client and social support network experiences in the mental health care system: By collecting multiple reports from similar participants we can categorize the likenesses among experiences and thus identify truths that have a higher probability of presenting in similar cases (Clark, 1998).

In regard to bias, I assumed that participants would report their experiences as honestly as possible and I would listen and analyze to the best of my abilities but that we would all bring a personal lens and biases to the interaction. Therefore I attempted to minimize bias by openly evaluating my assumptions and creating opportunities for self-reflection among participants. To challenge my own bias I tried to use value neutral questions and terminology. For example, I asked participants to tell me who they had sex with and what type of relationships they had with these people rather than ask them to identify as gay or straight. Though I had preconceived assumptions about what causes mental illness I asked participants what they thought caused their or their loved one’s mental illness and if it could be cured.
Since two obvious areas of possible bias were related to race and gender I attempted to create opportunities for the respondents and I to discuss the issue openly. I asked participants, “Do you think there’s any difference between being a man and having a mental illness and being a woman and having a mental illness?” And, “Do you think there’s any difference between being white and having a mental illness and being black and having a mental illness?” Though I had not originally intended to ask it, discussing race and gender with participants also led me to ask participants if they would have been more comfortable if I were a man or African American. This approach to conducting the interviews helped to create a climate that encouraged honest answers.

**Theoretical Model**

This research adopted the network-episode model (NEM; Figure 1) (Pescosolido & Boyer, 1999) to examine the social structures that influence mental health treatment for rural African American men with SMI and how the social structures interact. The network-episode model argues that, “[h]ow people respond to illness is as much a process of social influence as it is a result of individual action” (p. 406). The NEM consists of four factors: individual social content, social support systems, the illness career, and the treatment system. Pescosolido and Boyer (1999) assert that individual factors associated with the client, such as gender, age, income, illness symptomology, and access to care influence their social support system, illness career, and treatment system. In turn, these three systems influence each other. For example, social support systems’ beliefs about health care professionals (community network content) may influence when a client leaves treatment (illness career key exits) or the treatment system’s size and density (treatment network structure) may influence delay and spacing of consultations (illness career key timing and sequencing). The NEM considers the interactions between “the
illness career, social support system, treatment system, and social context” to help researchers conceptualize “the patterns and pathways of practices and people consulted during an episode of illness” (p. 407).

*Figure 1*

*Network-Episode Model (Pescosolido & Boyer, 1999)*

This research attempts to understand the “patterns and pathways” of communication between social supports, clients, and treatment agencies and, in particular, what messages are passed along the pathways. Previous research focusing on rural African Americans demonstrated that even the presence of a support network influences perceptions of mental health treatment: Participants who had less social support and fewer adults in their home experienced greater levels of perceived stigma in regard to mental illness (Murry, Heflinger, Suiter, and Brody, 2011).
The network-episode model is an example of social network analysis. While social network analysis can refer to a statistical analysis approach it is also a larger theoretical movement defined by examination of agents within a network and analysis of the network as an entity (Valente, 2010). With social network analysis and network-episode models as guiding theories, this research is focused on studying rural African American men with serious mental illness in the context of their primary social support networks in addition to understanding and comparing the networks as systems.

**Qualitative Methodological Approach**

Due to this project’s research questions and theoretical basis a qualitative methodological approach and general inductive analysis were used. Quantitative analysis of the survey data found that social support was the only variable where African American men who stayed in treatment differed from those who had left. There was no further information available from the survey data and the small sample of interest (N=41) made further quantitative data collection untenable. When considering what questions to pose to participants it became clear that little was known about how clients and social support networks interacted around mental health and how social support networks of adults with mental illness perceived or interacted with the mental health care system. An exploratory approach to elicit thick description was necessary. Thomas (2006) recommends the use of inductive analysis in qualitative research “to condense extensive and varied raw text data into a brief, summary format [and] to develop a model or theory about the underlying structure of experiences or processes that are evident in the text data” (p. 238). Qualitative interviews were inductively analyzed to summarize common themes in experiences with and opinions of mental health care among AAM-SMI client and their social support networks. These themes were then used to develop a theoretical model describing how social
support and mental health agency interactions influence the community environment and attitudes toward mental illness and treatment. This model is presented in the discussion section.

**Research Design**

This research utilized a two stage sampling approach. The first stage contained a purposeful sample of 26 African American men in community mental health care who previously participated in the study Climate, Diversity, and Outcomes in Rural Mental Health. Semi-structured qualitative interviews were used to explore the men’s personal experiences in mental health care and articulate the men’s observations of the processes and messages of interacting client, social support, and agency networks.

The second sampling stage included 26 people identified by the first stage clients as vital members of their social support network. Social support network members participated in semi-structured qualitative interviews exploring how they understood their role in their loved one’s mental health treatment as well as described their experiences with and opinions of the mental health care systems.

**Client Participants**

**Sample characteristics.** A sample was selected of 26 men from 41 who participated in the study Climate, Diversity, and Outcomes in Rural Mental Health. All of the men were African American, diagnosed with a serious mental illness, had been receiving services for at least 3 years at a community mental health agency, and had remained in treatment over the course of data collection for the previous study. The men ranged in age from 32 to 58 years old with a mean age of 46 years. All of the men paid for their mental health care services using Medicare or Medicaid. Their average annual income was $8,522 with a standard deviation of $1,266. The majority of the men had never been married (81%, n=21) but three were divorced.
(11%), one was widowed (4%), and one was married (4%). Similarly 58% of the men had no children (n=15), 23% had one to two children (n=6), 15% had three to six children (n=4), and 4% (n=1) chose not to respond.

**Sample recruitment.** I attempted to contact all 41 men via phone call, letters to their homes, letters hand delivered by mental health providers, and visits to their homes. Of the 41 men, two declined to participate, three had died, and ten had changed their phone numbers, moved, or did not respond to calls or letters. The remaining 26 men agreed to be interviewed for this research. Upon making contact I explained the current study and asked them if they would be willing to meet and discuss the research. Participants who were willing to be interviewed were also told that I wanted to interview their family or friends asked if they would be willing to refer me to members of their social support network. Participants who expressed interest in participating were asked to pick a location convenient to meet where I could provide a complete explanation of the research project and, if they consented, conduct the interview.

**Social Support Participants**

**Sample characteristics.** The participant sample was 69% female (n=18) and 31% male (n=8) and 85% African American (n=22) and 15% White (n=4). Social support participants ranged in age from 36 to 86 years old with a mean age of 60 and a standard deviation of 11 years. Eleven social supports (43%) reported having less than a high school education, three (11%) had graduated high school, seven (27%) had some college education, and five (19%) had graduated from a four year college. The majority of participants did not work (69%; n=18), six were employed full time (23%) and the remaining two worked part time (8%).

Client participants were asked to provide referrals to people they felt were key members of their social support network and were not restricted as to who they chose. As a result, 85%
were family or fictive kin (n=22), 11% were staff (n=3), and 4% were friends (n=1). It is of interest to note that when staff were identified as key social supports both staff and clients stated that their relationships were more than just professional and that they considered each other friends or co-workers. Relationships are identified in more detail in Figure 2.

*Figure 2*

*Relationship Types in Social Support Sample*

![Bar chart showing relationship types in social support sample.](chart)

*Note:* The categories mother, father, sister, and brother include such variations as step-, fictive-, and -in-law.

**Sample recruitment.** Potential stage two participants were contacted by phone or letter and I provided a brief explanation of the research and assured them I had been referred by the stage one participant. Participants who expressed interest in participating were asked to pick a location convenient to meet where I could provide a complete explanation of the research project and, if they consented, conduct the interview. In two instances the first person identified by the client was willing to be interviewed but was never able to agree to a time for an in-person or telephone interview, one social support never responded to requests for an interview, and one
client declined to give permission for his social supports to be contacted. In the case of the social supports that were amenable but not available the next individual who was identified as a key support figure by the stage one participant was contacted. In one instance the second social support was interviewed and in the other the second social support also agreed to be interviewed but could not agree to a time for an interview. In the case of the social support who did not respond, this individual was the only social support identified by the client for an interview so there was no secondary person to contact. This resulted in three instances where a client social support was not available to be interviewed. In these cases the researcher contacted and interviewed a second social support from three other client participants.

**Instruments and Measures**

A client interview guide with brief-response and open-ended questions was developed (see Appendix A). The interview script explored three distinct categories posited to be related to therapeutic outcomes: Accessing and utilizing mental health care; appropriateness of care; and role of social support networks. In addition to the interview questions I used a social network chart, created by Carrie Pettus-Davis at the George Warren Brown School of Social Work at Washington University in St. Louis, as a visual aid to help participants think about who was in their social network (see Appendix B). Once the social network chart was completed participants were asked to use the map as a prompt for questions about the role of social support networks. These questions helped to identify who in the social networks provided problem solving or nurturant support. Problem solving support consists of behaviors such as giving people advice or tangible assistance while nurturant support is enacted through caring behavior that integrates people in a group or community (Cutrona, 1990; Goldsmith, 2004).
A social support member interview guide with brief-response and open-ended questions was also developed (see Appendix C). Questions were formulated differently for clients and social supports, but explored similar concepts. As in the first stage interviews, data collection focused on the three themes of access and utilization; appropriateness of care; and role of social support networks. The use of similar questions and structure in the interview format allowed information from both first-person and close observer viewpoints to be compared.

Data Collection

When asked where they wanted to meet for the interview the majority of client participants chose to meet with me in their homes though some chose to meet in other locations such as a fast food restaurant, a relative’s home, or their community mental health agency. All of the social support participants chose to meet with me in their homes except for one who was only available by phone. I took notes and audio recorded all the interviews except for one client and one social support participant who declined to be recorded and the social support interview which was conducted over the phone. I did not have the necessary recording technology to record the phone interview. During the non-recorded interviews I took even more extensive notes and transcribed as much as possible. For their participation interviewees received a $20 gift card to their choice of Wal-Mart or Dollar General.

Data Analysis

Brief-response questions allowed the immediate coding and quantification of respondent demographic data while open-ended questions allowed for unique participant responses. All audio recorded interviews were coded using ELAN (EUDICO Linguistic Annotator; Lausberg & Sloetjes, 2009). The theoretical approach applied to coding the interviews was thematic analysis. Boyatzis (1998) states that thematic analysis consists of three stages: observing a pattern, coding
the pattern, and interpreting the pattern. Thematic analysis can be used with all types of qualitative data and is particularly useful in the early stages of research because “thematic analysis enables the researcher to access a wide variety of phenomenological information as an inductive beginning of the inquiry (Boyatziz, 1998, p. 5).

One codebook was used for all stage one and stage two participants. This universal coding was used to identify consistent themes across participants. Once themes that represented interpretive agreement were identified the remaining themes were analyzed to determine if they coalesced to specific sub-groups who shared demographic characteristics or experiences that offered explanation. Qualitative interviews ultimately describe the experiences of the individual so some themes did not achieve interpretive agreement or sub-group distinctiveness but were unique and meaningful to the individual.

In the Results section significant themes identified in the interviews are presented. Counts indicating the frequency of theme occurrence are provided and client and social support responses are compared to identify cross-participant agreement or disagreement. Quotes that illustrated the identified themes are also presented in order to allow the participants’ voices to be present and readers to better understand the meaning behind the thematic codes. In order to understand the make-up and function of social support networks of rural African American men with serious mental illness social network charts for all client participants are summarized in tables and three social network maps are presented to provide a visual representation of the client social support networks.
CHAPTER 4

RESULTS

This chapter summarizes and presents key themes identified in participant interviews. The results describe client social support networks, client and social support reports of interactions with community mental health care, participants’ views on race and gender, and feedback about how mental health care for African American men can be improved. Brief demographic descriptions of client participants can be found in Appendix D and of social support participants in Appendix E. All names are pseudonyms.

Context Systems

Social Support Network Composition

Client participants were asked to complete a social network map in which they provided the name, relationship, age, and gender of people they considered family by biology or choice. Clients reported social networks ranging from one to 17 people. The average number of people in clients’ networks was 7.4 (SD=4.5). Immediate family and friends were the most common network relationships. Networks were 50% male (n=96) and 50% female (n=95). The reported ages of the social support network members ranged from 15-88 with a mean age of 50 (SD=15).

Table 1

<table>
<thead>
<tr>
<th>Relationship type</th>
<th>total social supports (n=191)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate family</td>
<td>114 (60%)</td>
</tr>
<tr>
<td>Friends</td>
<td>37 (19%)</td>
</tr>
<tr>
<td>Extended family</td>
<td>13 (7%)</td>
</tr>
<tr>
<td>CMHA staff</td>
<td>15 (8%)</td>
</tr>
<tr>
<td>Church members</td>
<td>9 (5%)</td>
</tr>
<tr>
<td>Romantic partners</td>
<td>3 (2%)</td>
</tr>
</tbody>
</table>
Table 2

*Prevalence of Relationship Type across all Client Social Support Network Charts*

<table>
<thead>
<tr>
<th>Relationship type</th>
<th>clients reporting (n=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate family</td>
<td>23 (89%)</td>
</tr>
<tr>
<td>Friends</td>
<td>13 (50%)</td>
</tr>
<tr>
<td>Extended family</td>
<td>11 (42%)</td>
</tr>
<tr>
<td>CMHA staff</td>
<td>9 (35%)</td>
</tr>
<tr>
<td>Church members</td>
<td>4 (15%)</td>
</tr>
<tr>
<td>Romantic partners</td>
<td>3 (12%)</td>
</tr>
</tbody>
</table>

**Types of support.**

Researchers have identified different types of support provided in social relationships. The two primary types are problem solving support and nurturant support (Cutrona, 1990; Goldsmith, 2004). Problem solving support is comprised of informational and tangible support and constitutes provision of services, resources, and advice. Nurturant support provides emotional and network support which helps people feel cared for and part of a community. After creating a list of family members, client participants were asked questions such as: Which members of your family help you by doing things like making you food or giving you a ride when you need to go somewhere?; Whose advise do you take?; and Who can you count on to make you feel better when you are upset? On average, clients identified 3.8 people who provided problem solving support (SD=3.1; range: 0-15) and 3.3 people who were sources of nurturant support (SD=2.8, range: 0-9). Immediate family members were the most prevalent providers of both problem solving and nurturant support. All other types of social relationships were identified as providers of support but were noticeably less prevalent than immediate family members.
Table 3

*Support by Relationship Type as Reported by Clients*

<table>
<thead>
<tr>
<th>Relationship type</th>
<th>clients reporting problem solvers (n=26)</th>
<th>clients reporting nurturants (n=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate family</td>
<td>21 (81%)</td>
<td>21 (81%)</td>
</tr>
<tr>
<td>Friends</td>
<td>7 (27%)</td>
<td>8 (31%)</td>
</tr>
<tr>
<td>Extended family</td>
<td>6 (23%)</td>
<td>5 (19%)</td>
</tr>
<tr>
<td>CMHA staff</td>
<td>7 (27%)</td>
<td>3 (12%)</td>
</tr>
<tr>
<td>Church members</td>
<td>2 (8%)</td>
<td>3 (12%)</td>
</tr>
<tr>
<td>Romantic partners</td>
<td>1 (4%)</td>
<td>2 (8%)</td>
</tr>
</tbody>
</table>

Table 4

*Support by Relationship Type in Client Social Support Network*

<table>
<thead>
<tr>
<th>Relationship type</th>
<th>problem solvers (n=96)</th>
<th>nurturants (n=77)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate family</td>
<td>61 (64%)</td>
<td>45 (58%)</td>
</tr>
<tr>
<td>Friends</td>
<td>13 (14%)</td>
<td>16 (21%)</td>
</tr>
<tr>
<td>Extended family</td>
<td>6 (6%)</td>
<td>5 (6%)</td>
</tr>
<tr>
<td>CMHA staff</td>
<td>13 (14%)</td>
<td>6 (8%)</td>
</tr>
<tr>
<td>Church members</td>
<td>2 (2%)</td>
<td>3 (4%)</td>
</tr>
<tr>
<td>Romantic partners</td>
<td>1 (1%)</td>
<td>2 (3%)</td>
</tr>
</tbody>
</table>

Social Network Maps

Below are examples of specific social networks for three client participants. Andrew reported a social support network of eight people, approximately the average number of supports, comprising three different categories of relationships. He reported no overlap in providers of problem solving and nurturant support and the social support roles were aligned along stereotypical gender roles. When social supports appear in the maps but are not identified as problem solvers or nurturants it means that the client identified the person as a member of their overall social support network when completing the social network chart but did not name
the person in response to the specific prompting questions about who they relied on for different types of support.

*Figure 3*

*Andrew’s Social Support Network Map*

Theo provided detailed responses in the interview and is quoted several times in this manuscript. He had a large social support network and lived in the same community as both his family of origin and family of procreation. He lived with his oldest son and daughter-in-
law, and described his relationships with his youngest brother by saying, “he would go to hell for me.”

Figure 4

Theo’s Social Support Network Map

Brian had a smaller support network and chose a staff member at the CMHA as his suggested social support to interview. Despite that choice he still reported that he had additional sources of nurturant and problem solving support outside of his mental health providers.
Figure 5

Brian’s Social Support Network Map

Mezzo Systems

The primary focus of these interviews was to understand how client and social support systems interacted with each other and community mental health providers. However, both clients and social supports were asked to comment on other mezzo level systems they interacted with in the community. Clients were asked to gauge their level of satisfaction and fit in four settings: neighborhoods, church (if they attended), the community they lived in, and the community mental health agency they received services from. Clients ranked them on a scale of one to four: one, not at all happy/satisfied; two, somewhat happy/satisfied; three, happy/satisfied; four, very happy/satisfied. The results are presented in Table 5. Forty-two percent of client
participants (n=11) declined to evaluate the church setting because they did not regularly attend a church and one of the participants declined to assign a number to his level of satisfaction with the CMHA.

Table 5

*Client Satisfaction with Mezzo Systems*

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>Min-Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighborhood satisfaction</td>
<td>26</td>
<td>2.9</td>
<td>1.1</td>
<td>1-4</td>
</tr>
<tr>
<td>Church satisfaction</td>
<td>15</td>
<td>3.1</td>
<td>.9</td>
<td>2-4</td>
</tr>
<tr>
<td>Community satisfaction</td>
<td>26</td>
<td>2.8</td>
<td>1.1</td>
<td>1-4</td>
</tr>
<tr>
<td>CMHA satisfaction</td>
<td>25</td>
<td>3.3</td>
<td>.9</td>
<td>1-4</td>
</tr>
</tbody>
</table>

*Note.* Possible scores range from 1 to 4, with higher scores indicating greater satisfaction with the setting.

Social support participants were also asked specific questions about how they felt mezzo systems viewed mental illness and mental health care. They were asked specifically about their family, if the client was a family member; the local African American community; and the community as a whole.

Table 6

*Social Support Assessment of Other’s Reactions to Mental Illness and Mental Health Care*

<table>
<thead>
<tr>
<th>Assessment</th>
<th>client’s family (%) (n=21)</th>
<th>community (%) (n=26)</th>
<th>Afr. Amer. community (%) (n=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>positive</td>
<td>10 (48%)</td>
<td>3 (12%)</td>
<td>3 (12%)</td>
</tr>
<tr>
<td>negative</td>
<td>2 (9%)</td>
<td>12 (46%)</td>
<td>14 (54%)</td>
</tr>
<tr>
<td>neutral/ no opinion</td>
<td>9 (43%)</td>
<td>11 (42%)</td>
<td>9 (35%)</td>
</tr>
</tbody>
</table>

*Family.*

The majority of social supports reported that their families had no definite opinions about mental illness or mental health care but a significant portion were accepting of the client’s mental illness and supportive of mental health care.
Ada: You know what, we don’t have a big family. It’s only a small amount of us. We just never second guessed it. We just deal with it the best way we know how.

Esther: Well, the family, they deal with him. They understand him. They take him out. They’re not ashamed of him.

Belinda: As far as my family, they just accept the way that he is. They treat him normal. They don’t complain about anything.

**Community.**

However, when discussion turned to the broader community and its perceptions of mental illness opinion quickly tipped from positive or neutral to predominantly neutral or negative: Social supports felt that people with mental illness were treated poorly and looked down on in the community.

Karina: They don’t care. They don’t understand. I don’t think they understand what to expect.

Ada: They probably scared of them. Like I said, not until it happens to someone in your household, you’d think they was just crazy. I know that’s not a nice term to say but you don’t understand until, a lot of us don’t care until it happens to us or to a family member or someone you know close by…When he stays out here, [neighbors] were asking his whereabouts if they saw him outside, maybe saw him mumbling to himself, they was saying he’s crazy. The police pulled up, asked him who he was.

Irene: I think there’s still stigma attached to it just because they don’t understand it. If you haven’t been involved with someone with mental illness, if it’s not in your own family. It’s a stigma they shy away from it, they don’t want to know. I still think it’s a
problem. Maybe not as bad as it has been in the past, because it’s more out there now, people do know about it.

Louis: [Our family] don’t feel bad about it or anything. It’s just the people in your community that think they know you or they think they know what you’ve been through or what the purpose of the place you went to was for. Which they really don’t know anything about it.

**African American community.**

When social support participants were asked to differentiate between how the overall community and how the African American community viewed mental illness the tone moved from neutral-negative to predominantly negative. Respondents provided a specific set of explanations for the negative response from the African American community. In particular, they felt the African American community had less knowledge and education about mental illness, distrusted the mental health care system, and were more likely to assign personal blame to clients rather than accepting mental illness as a disease.

  Preston: I think we don’t accept the fact that there may be a mental problem as easily as the Caucasian race does. I think that we don’t, mental illness is kind of a negative thing. They’ll say, “Oh, that boy, ain’t nothing wrong with him. He’s just so and so.” When maybe he really does have a problem. But we don’t say, “Ok, he needs psychological help. He needs counseling.” We might just say, “He needs his butt whooped.” When really the kid has a problem and we don’t seem to accept it or see it as a mental health problem.

  Zora: I just think a lot of us aren’t educated on the issue, that’s why we don’t understand. I think the White community, probably for the most part a lot of them are
better educated on the issue. Maybe that’s why they deal with it more. Like I said, the African Americans, we’re just ignorant. I’m serious. I’ve seen people be mean to people that are disabled and how you could do that I wouldn’t understand.

Xarah: We’re too hard on each other. We’re very hard on each other. We see each other got a problem, I’m gonna tell you, we can be the hardest, cruelest ones to each other. I don’t have nothing to hide. I’m for real. “Oh, that person’s spaced out. He’s nuts.” And all that, you know. They just put him in a box. They separate themselves from him… I think it’s out of ignorance. It seems like White people have more compassion or more understanding of the disease. I don’t think that a lot of Blacks get out and research what’s going on in the person. They just assume the person’s nuts. A lot of us don’t consider it as a disease.

Tabitha: When I was growing up the worst thing that could possibly happen to you was being sent to the state hospital. And I don’t know how true it was, it was just something that I was told back then, and I overheard other people repeating, was that you could get $50 for every person that you turned in. And that there were a lot of people that were there because the family didn’t want to be bothered with them, or that they wanted control over their property or money or what have you… This was wide spread in this area. So, that may have a lot to do with it. You know, some things, to me it takes a long time for people to get over it. And this was generation after generation after generation. And I think only now, I’ll say with my generation, it has started to ease up a lot… But you know, if grandma’s sitting back there saying, “Yeah, I remember when Mrs. Jones was stuck in there and there wasn’t a thing wrong with her.” It may make Mrs. Jones’ grandson or great grandson a little hesitant to go and see about this.
Social Support Engagement in Mental Health Care

Client Perceptions

Clients were asked if their social supports were involved in the client’s mental health care, had contact with the client’s mental health providers, or helped with medication. Half of the clients (n=13) stated their social supports were involved in their mental health care, 46% (n=12) said they were not involved, and 4% (n=1) didn’t know. When clients who said their social support were involved were asked for further detail such as who the social supports talked with or what they discussed the clients provided general, vague responses that indicated they did not have a clear sense of how social support network members were engaged in treatment.

I: Do any of them ever talk to your therapist or case manager?

Elijah: My mom.

I: What do they talk about?

E: Well see, that’s the thing, I don’t be sitting right there. I don’t ask her what was said.

Oliver: My sister. She talks to my nurse

Interviewer: What do they talk about?

O: They talk about what I’m doing. What I did back in the day. My history.

Interviews with Elijah’s mother and Oliver’s sister revealed that Elijah’s mother was in contact with treatment providers but Oliver’s sister had such a negative view of the CMHA she did not speak with staff. Despite not being sure about who their social supports spoke to or what they discussed, some clients like Andrew extrapolated that their social supports were guiding treatment or involved in major decisions.

Andrew: Yep, my mother
Interviewer: So does she talk to your case manager? Your therapist?
A: Uhhh, I think she goes straight to the doctor.
I: What do they talk about?
A: That I don’t know.
I: Do you think your mom being involved, talking to the mental health agency, do you think that’s helped you?
A: She speaks, tells him what he needs to know. Cause I don’t have to explain what she already knows about me. She do all the explaining. How she wants it done. I think that’s how I got the shots. Cause she decided to speak for me. You know mommas know what their kids need and want. But I never got in that conversation [with her]. Cause she knows what I need, whether I want to believe it or not.

When Andrew’s mother, Judith, was interviewed she stated she had not had contact with the agency for several years and had previously only attended social events there. Follow up questioning with other client participants revealed that peripheral or one-time interactions were sufficient to cause clients to consider social supports involved in mental health care.

Interviewer: Does anyone in your family, does anyone else from that list, are they involved in your mental health care here?
Brian: My mom.
I: And does she ever talk to your therapist or your case manager?
B: She can but she doesn’t have to. I signed a paper saying she’s able to call me here. I think that’s called release of information. She has permission to call me here but she really never has to.
I: Does she ever? Has she ever?
B: All she said was one time she called and talked to somebody that was really rude and I said, “That person’s not here anymore.”

Interviewer: So was anyone in your family involved with your care at the community mental health agency?

Theo: My son. That’s the one that was picking me up. Then my sisters, when they lived here, they would take me.

I: And so mostly they gave you rides. Did they ever talk to your therapist?

T: Uh-uh, no.

I: And did they ever help you with your medication or did you handle that yourself?

T: Well, they help me if I run short at the end of the month they pay for it. Tell me not to worry about it.

Social Support Perceptions

Though 50% of clients (n=13) stated their social support network was involved in care, only 31% (n=8) of the social support network members reported that they participated in the client’s mental health care. Furthermore, that number includes the three social support members who were also employed at the community mental health agencies: If staff are removed from consideration the percent of active social support members falls to 22% (n=5).

When social support members were asked about their involvement the two most common reasons identified for not engaging with community mental health agencies centered on privacy and who has the power to invite social supports into the private setting of mental health care. Ten (56%) of the 18 non-involved social supports ceded to agency staff as the arbiters of access. If they did not receive an explicit invitation, they did not feel comfortable approaching staff.
Some social supports, who had approached staff in the past and experienced push back, assumed they were not welcome or needed in discussions of mental health care. Conversely, six of the respondents (33%) indicated they avoided involvement in the mental health care system out of a wish to respect client privacy and autonomy.

**Staff as gatekeepers.**

In discussion of staff interactions the question of explicit invitation was mentioned several times, such as by Violet.

Violet: If they open, have an open house, we’ll all be able to see… We need to be more involved in their activities. Even just once a month or once every six months. We need to know, what are they doing? Do like an open house and see, this is what they’re doing. Like I said, I do know that they do field trips. But other than that I don’t know if they have classroom participation? Do they do book work? What do they do?...At least I’d know what he was doing. I just know he goes down there...I would have time. I would make time. But I think they just need to open it up.

Other social supports described their fluctuating involvement. When staff who valued social support involvement were present at the agency and took the initiative to reach out, family members participated in mental health care. However, when these individual staff left the agencies there were no policies or procedures in place to ensure continued social support involvement.

Esther: Oh yeah, [the doctor] was sweet. She died…She was a sweet person. She was really on top of things. We’d have conference meetings. She’d call us in for conference meetings. They don’t do that now. They don’t do it anymore. We used to go and have a
table with four or five of us sitting there talking about [my son] and how they were responding and this and that….She was a good doctor.

Judith: I used to go down there. The lady that used to work there, she would call and let me know special things is coming up and when she called and let me know I’d go down there.

Nate: The last couple times I went they didn’t even ask me to come in. They just assume that everything’s going ok. As long as he’s progressing they more or less want his responses and they don’t want me to interact in his conversation when he’s talking. So usually they take notes from that and he seems to be doing well so I don’t go in there.

Another issue that hindered social supports from feeling comfortable approaching staff and seeking information was high staff turnover rates which left social supports feeling unsure who worked with their loved one and who they should contact.

Helen: No, I don’t talk to [the staff]. Yeah, they’ve always got different staff. Sure enough I don’t [talk to them].

Milo: I’ve talked to Dave? Uh, I think his name is Dan? They’ve done switched up so much. I’ve talked to Dan, Kathy….I’ve talked to them all.

Tabitha: I developed relationships with some of them. Course the only problem is people come and go a lot. That’s the hardest thing. Because just as soon as I recognize somebody and know what their name is I’ll ask my son and he’ll say, “Oh no, she’s not there anymore.”

**Misinformation about HIPAA.**

Some members of the social support networks had clearly spoken to mental health staff and been informed of confidentiality restrictions. The Health Insurance Portability and
Accountability Act of 1996 (HIPAA) set clear guidelines for how consumers can access their personal health information (PHI) and give permission for others to do so via a brief release of information (ROI) form (DHHS, n.d.). However, information about ROIs or the simple one page form did not appear to have been provided to social supports, leaving them often unclear of what steps they needed to take to be allowed access to confidential information or left feeling they were simply not allowed to interact with staff.

Sandy: Cause you know what, I’ve never been there. So I can’t really tell you what they do when he gets there. Because I had even asked one time, “Can you tell me what’s going on?” He said, “[Your son] will have to tell you himself. If I were to tell you he’d have to give me written permission.” So I’ve never known the diagnosis.

Louis: No, cause in the first place that’s confidential. They keep everybody’s profile confidential. So whatever goes on in there with them stays there with them. Now you can sign a piece of paper if I wanted to find out, ask him if he’d sign a piece of paper stating that they can release [his file] to me to look at but I couldn’t just walk up [to the agency] and look at it. No, no, [I’m not interested in his file.]

Frustration with confidentiality restrictions was not a theme solely limited to social support network members who were not involved in care. Even people who had overcome barriers in order to participate in their loved one’s care described onerous paperwork and requirements.

Xarah: At first they don’t want the family to have nothing to do with it. What is your problem? Say I notice my son is not taking his medication or he needs to be put on a watch program or something like that. “Well do you have power of attorney over him or anything like that?” (sigh) That can be very dangerous. So you have to go get all this
paperwork. You know, this is my son. You’re supposed to be helping my son. You see I’m very concerned but I have to wait and go get all this and then come back. That’s where I see that there is a leak in the system.

**Privacy and respect for adult status.**

In addition to wanting agency staff to welcome them in to the treatment setting, social support respondents were concerned that clients also needed to permit their involvement. Social supports repeatedly mentioned that clients were adults and therefore had to be allowed a certain amount of independence. When discussing client adulthood social supports did not frame this status in a legal sense, ie. focusing on what involvement the CMHA could legally allow but rather social supports were concerned that their behavior not undermine client independence or developmentally-appropriate identity as an independent adult.

Tabitha: I try to be there, not just as a parent, but I also try to give him his respect as an adult. I try to listen and not judge. It’s so hard, I have to sit on my hand and bite my lip, but I try not to offer advice unless he asks for it.

Quiara: If it ever come down to a time that they want to sit down and talk with me. If they request it [my son] will call me and tell me and we’ll set up a date. But for me to go down there and say, “Hey, I want to know!” He’ll tell me what he wants me to know.

George: He’s in control and he’s got help so I just give him his space. I do try to check in on him every now and then to make sure he’s ok. Just being there for them when they really need somebody, sometimes when they don’t. But you can tell when there’s something bothering him but in the main run we do ok. Yeah, I do [ask when something is bothering him], but if he don’t want to say anything I don’t go any
further…Just like I said, he’s doing fine. I stay my distance and let it be. If he’s got a problem you can bet he’ll let me know or show up.

Violet: They’re adults. I can go to my granddaughter’s school and just go in and just sit in. But you go on down there to an adult center and you pop in, you just don’t do that!

**Masculinity.**

In addition to discussing clients as adults, social supports also touched upon clients’ status as adult men. When discussing adulthood social supports also referenced ways in which clients fulfilled hegemonic masculine roles such as family provider or worker. Social supports shared these examples as illustrations of how the client was able to function independently and fulfill societal roles without assistance from social supports or CMHA staff.

Quiara: I said, you at the age now where you need your own place. It’s not come stay with momma. It’s not come stay with daddy. It’s not come stay with nobody. You need your own spot…He’s ready to go.

Xarah: He’s a man, you know. So I helped him get his own place. Because I feel if you treat people like that. They got some type of handicap, you see there’s something they are capable of doing, you don’t let them do that they’re gonna lose that ability too.

Violet: He takes care of his wife. Now I give him that, he do take care of his family. He makes sure she has her medicine…I take care of his money. He’ll come by here, “I need to go to the grocery store to cook.” He cooks. He does take care of his family, I have to give him that.

Preston: He’s talked about working and I think that’s been good for him. Because when he was younger he was the one that always worked. He always had a job and he
always was the one that managed his money better than his brother did. And I think he feels a little bit more independent by having work...When his mother passed away he was the one that financially took care of her arrangements so I think he’s done well, for the problems that he’s been confronted with.

Staff Perceptions

Three staff members were identified as key social supports and participated in the interviews in this role. While staff were participating as social supports they also provided insight into community mental health agency staff perceptions about familial involvement. Two of the staff members stated that they thought clients had minimal support from family or friends and that agencies had to provide that support. While support from agency staff is certainly necessary and positive, these views run counter to the reports of the clients and their social support networks, who clearly felt that they had significant relationships and interactions in daily life.

Yvette: Clients don’t have a lot of family support or friends so staff have to step up and be that.

Franklin: Especially in this environment, there’s a lot of dysfunction. A lot of the guys, they might have family, but they may have burned some bridges along the way. They might have family and they may even visit. But I don’t think the family understands. I think for many of them, we are the family, though they may have relatives close by. Yeah, I think we’re the family for a lot of those guys. When you’re in the midst of your addiction and your mental health and you’re out in the streets acting out. You know the families may have had to go through that many, many times. So they may say, “Well, I’m sure glad [he’s] better now.” but that still lingers. And they may not
understand why. Why is he acting crazy? Couldn’t he see what he’s doing? Family is important but there’s so much dysfunction there that I think the [community mental health agency] provides that gap there, that security, or whatever.

Impact of Social Support Non-Involvement

Social support non-involvement impacted social support satisfaction with care and their support of treatment protocols. Compared to social supports who were involved in their loved one’s mental health care, non-involved social supports more often reported negative or mixed opinions of community mental health agencies when asked about their level of satisfaction with mental health care. In addition, those social supports not involved with care were most likely to report dissatisfaction with medication side effects and even report they supported non-compliance with prescribed medication regimes.

Social support satisfaction.

Of social support participants who were engaged in care (n=8; including CMHA staff), 100% were satisfied with care. Of the social support participants who were not engaged in care (n=18), 2 (11%) had clearly negative opinions about the CMHA and 8 (44%) reported mixed or neutral feelings about the CMHA. Even when identifying treatments or outcomes they were pleased with, they included caveats about problems they had encountered.

The most dramatic example of non-involved social support negativity occurred while the researcher was interviewing a client in his family home. The client’s fictive kin brother was informed by someone in the neighborhood about the interview and assumed the interviewer was a case worker from the CMHA. Several months prior a staff member from the CMHA had told the family that they would perform a home visit but there had been no further communication
and the brother assumed a CMHA staff person had finally arrived without making arrangements beforehand.

Ross: What are you doing in my house!? Like you can just come in here whenever you get ready!? What’s going on!? What are you here for!? [Interviewer explains who she is and why she is conducting the research. Social support participant explains he thought researcher was from CMHA.] [The CMHA is] not doing anything. They don’t do nothing down there. That’s a waste of money. [The clients] just go down there and fight. They pick and choose, you know they got some they like and some they don’t like. That’s money the government should cut out, for real, so all those sons of bitches don’t have a job. They don’t do nothing! They don’t do nothing down there!

Quiara: He enjoys it but, you know, it’s limited what they can do. If he had a real psychiatrist that really wanted to get down in there and pull that soreness up out of him, I think he could come back.

Milo: Mental health care is good. Back when I was growing up people would be on the corner slobbering at the mouth and people would laugh at those people. It was a disgrace…Modern day, where my son’s at, they be at a gain and at a loss at the same time. I think the medication that they give them makes them blow up, makes them swell up. My son didn’t always look like that. I remember when he was weighing 140 some pounds, now he’s right at 300…Plus, they only give him $20 a week…And once you break a $20 bill in the store, as you know, tax and everything, you haven’t got nothing hardly left.
Udell: They just give him shots and stuff like that. Try to get him to calm down or whatever. They try to fix things down there. That’s about the only thing I know about them people…I just leave it alone.

**Awareness of CMHA services.**

Social support participants, excluding agency staff, were asked if they were aware of the community mental health agencies in their area prior to their loved one receiving services. The majority, n=11 (48%), reported that despite living in relatively small communities they were not aware of the CMHAs existence prior to the client beginning services. Additionally n=5 (22%) knew the agency existed but did not know anything about the services it provided, n=6 (26%) had positive opinions of the CMHA due to word of mouth and other personal experiences, and n=1 (4%) had a negative opinion due to stigma associated with mental illness.

Ophelia: I been knowing about the [CMHA]. My brother used to go there. He was mentally ill. He was schizo. He’s dead now though. Then my daughter used to work at the [agency]…Cause the [agency] been here a long time. I appreciate that they did have that place here.

Tabitha: I went to see the doctor and took my mom. Everybody was very helpful. Very cordial. They didn’t make you feel like you were a freak, or something’s wrong with you, or why are you here? They made you welcome.

Ada: Yes, I did [know about the CMHA]. Only because I had a friend that actually stayed next door to me, she’s actually younger than me. When she was going through her LPN classes, I forget what kind of degree, maybe an associates, but they worked there. And she just told me the kind of stuff they did.
Sandy: Well, I had been there, I don’t know if it was before I got my degree or after I got my degree, but I have applied for a job there before. And then when he, [the client], was in the fifth grade his fifth grade teacher kept telling me I needed to take him out there to get him looked at because she thought there was something going on with him.

**Medication compliance.**

Medication was frequently mentioned by social supports. They typically did not differentiate between different types of medications or their purposes but referred to them simply as pills or shots. The focus on medication may be due to the fact that it is one of the physically tangible indicators of mental health care. While social supports might not understand what was occurring during therapy sessions and psychosocial day treatment, they could observe the prescribed medications and their side effects. Non-involved social supports often structured discussions of medication around the negative side effects inherent in anti-psychotic medications: weight gain and lethargy. Some of the non-involved social supports also volunteered that due to their dislike of the heavy medication regime or medication side effects, they did not insist that the client consistently take his medication.

Helen: He don’t take it regularly that I see, but he takes it. It makes him sleepy. He don’t want to be going to sleep, especially on church day. He goes to church every Sunday and so he’ll be going to church and he don’t want to look all (sentence trails off). I understand because I see the way it makes him look and I don’t like the way it makes him look. When he’s in church he’ll just be praising God, but when he’s got that stuff in him he can’t do nothing. And I don’t like that.
Esther: I watch his medication pretty good. I’m not going to give him something that I don’t think that he needs. …They gave him blood pressure meds and I didn’t give it to him. I don’t think it’s a problem. I monitor it myself. If he needs it I’ll start giving it to him.

Carol: But like I say too, the pills don’t help. You can’t assume that pill is going to do something for somebody and it’s not doing anything. Or it’s making matters worse. Cause I’ve seen people, I’ve had a niece, they gave her those pills and it ate her brain up. Or they couldn’t get off of them, they get bad headaches. Then you gotta go through more pills in order to get over them pills. The pill just ain’t the solution all the time. The solution is, if it’s helping somebody, that’s good, but if it’s not, don’t force it. Because I’ve seen too many people, you know when you taking them pills and you get off them you get bad headaches. You can’t function, period. And then after that, if you want to get off them, you got a problem somewhere else in your body. I don’t think that’s good for the counselors to push pills down people.

Violet: Just walking around, they like zombies. That’s the way [he] used to be. He’d just be so full of medication he would be like a zombie. He’s supposed to get shots but he doesn’t do it. He doesn’t do it. He’s better without it I think…He didn’t want to do it and I didn’t force him. Because I knew it was, I thought it was part of the shots. Maybe not, but he’s been pretty good ever since. If it ain’t broke, don’t fix it.

Race and Gender

Racial Impact on Mental Health Care

Clients and social support participants were asked if they thought there were any difference being White and having a mental illness versus being Black and having a mental
illness. The responses were quite similar between clients and social supports, with 38% (n=10) of both groups reporting that racial differences existed in mental health care. However, the reasons provided for why disparities occur were slightly different between the two groups. Clients felt that African Americans were discriminated against while social supports were more likely to cite difference related to economic status and White privilege.

**Clients.**

The majority of client participants, (n=12; 46%), denied observing racial differences in mental health care, 4 (15%) could not say with certainty if disparities did or did not exist, and 10 (38%) believed that racial disparities existed in mental health care. Of the clients who felt disparities existed 100% felt African Americans were discriminated against: The primary reason given for why African Americans with mental illness experienced disparities was general racism resulting in inferior care.

Douglas: I think that [the mental health staff] are frightened of [Black people with a mental illness]. Because I’ve seen White clients go off. The girl that lives over here, she’s went off, cussed them people, throwing her purse. They didn’t call the police on her. But [a Black woman] she went over there and had the same type of episode and they called the police on her. I’ve witnessed this!

Oliver: Yeah [I think it’s harder for black people]. Because of our color. Sometimes they call you nigger. Get away from my house! Get away from my street! They hate nigger.

Walter: It’s still going on that Black people have a harder time getting help, in some ways, than White people.
Theo: Yeah, I think you get more help if you’re White than Black. It took me three years to get a medical card. I had a hard time to get my disability and these other [White] guys I know they’re on disability and they didn’t have to go through what me and other guys did.

**Social supports.**

Similarly 14 social support participants (54%), did not feel racial differences existed in mental health care, 2 (8%) were unsure if disparities existed, and 10 (38%) believed that racial disparities existed in mental health care. Of the social support participants who felt disparities existed, 7 (70%) felt that African Americans experience disparities, primarily because White people were generally privileged or handled mental illness more effectively. The remaining 3 social supports (30%) felt that disparities were not necessarily racially linked but rather the result of differences in socio-economic status, which did generally coincide with race.

**Race.**

Irene: I don’t know if it is as far as a doctor’s view or a clinician’s view but in the White and Black community, yes I think there is a difference. The Black community says, It happens here, it stays here. You don’t talk about it with people because then that causes problems. So I think yeah, there’s a difference. I think White people more apt to go express themselves, and Black people just want to stay home and not face it.

Quiara: White people have this glow about them. Black people don’t because they’re uncertain. That’s the only difference. And I’m not saying that there isn’t a lot of White folks that have not had a silver spoon in their mouth. I’m not degrading either race, but that’s just the way it is.
Tabitha: Yes. I feel like the White community, and I’m not being prejudiced, I’m just stating what I believe to be the truth, I feel like they have more access to better care and programs, you know, outlets and everything, than the Black community does. Also, I think the White community is more accepting of mental illness than the Black community is.

Socio-economic status.

Preston: I think that economically the Caucasian race has more financial ability to get help, so therefore if I don’t have the money to go, then I might not get treatment as quickly as someone who has the money. Counselors sometimes can detect problems. If I don’t go to counseling, then there’s no way for them to detect my problem. So I think medical facilities are more available to ones who have money, so I would assume that mental health treatment would also be.

Yvette: If anything there probably is still prejudice. Maybe not strictly about being African American but around being poor. Because when a person is poor, if they do try to get the services like food stamps, welfare, I still think that the vast majority of people who work look down on people. They don’t see behind the scenes or reasons. It’s just like, Oh did you see what that person just bought with the food stamps? It’s like, values judgment.

Franklin: I think it’s socio-economic. That would be as far as the care you get. As far as socially I don’t know. If you talk about, I suppose there’s different cultures have different viewpoints. Especially if, for example, you are fairly fundamental in your religious beliefs. Then you are gonna have a certain (doesn’t finish sentence). As far as care I would think it would be more socio-economic than the color of your skin. And if
there’s more African American people in poverty that would just mean there’s more
African American people with problems and not being able to access health care…I think
it’s more socio-economic. If you’re in poverty you don’t have the resources. I would
think it’s more socio-economic. If you’re Black and have a good job and good insurance
you get the same care as anybody.

**Gender Impact on Mental Health Care**

Clients and social support participants were asked if they thought there was any
difference being a man and having a mental illness versus being a woman and having a mental
illness. Eleven clients (42%) and 13 social supports (50%) believed gender disparities existed.
The all-male sample of client participants felt that men faced more hurdles in mental health care.
Both clients and social supports felt that disparities were the result of gendered stereotypes and
expectations that influenced how clients sought care and how society judges people with mental
illness.

**Clients.**

Nine (35%) of client participants felt there were no gender-based differences in mental
health care and 6 (23%) were unsure if gender based differences existed. Among the 11 (42%)
participants who reported gender differences, 8 (73%) said that having a mental illness was
harder for men, while 3 (27%) thought women with mental illness suffered more. Clients who
thought mental illness was harder for men attributed this to women being more willing and likely
to get help, while those who felt it was harder for women traced this to men being tougher than
women or society’s higher expectations of women’s behavior.
**Harder for men.**

Xavier: Women are stronger than men because of childbirth. They handle pain better. Women go to the doctor more and take better care of themselves.

Douglas: Women are gonna be more open about what is going on with them, whether they get the right reception for it or not. And men is gonna hide, they’re not gonna be open, because they’re gonna be perceived as weak or not able to sustain what a man is supposed to be. Whereas a woman is expected to be more open about her feelings.

Joshua: A woman gets more help or the problem is directly dealt with. Whereas a man, the problem is dealt with over a period of time, whatever time they feel they need in order to find whatever the problem really is. And even housing here, it’s easier for women to get an apartment than it is for men. Because the men drink and do drugs. I don’t do drugs and I don’t drink.

**Harder for women.**

Lance: [Society] puts more pressure on the females than they do on the males. It’s as if they want the females to be perfect. It’s just like, looking at a woman drink and get drunk, they have a big commotion about it. But when a man get drunk, it’s cool, hats off, he had one too many. It’s similar to that too with mental illness.

Theo: Today, I’ll be honest with you, I think that guys are stronger than women. I’m not trying to be a male chauvinist pig. I think the guys are not 100% stronger, maybe 3 or 4 % stronger because they’re men.
Social supports.

Eleven (42%) social support participants felt there were no gender-based difference in mental health care, and 2 (8%) were unsure if gender-based differences existed. Among the 13 (50%) of social supports who reported gender differences, 7 (54%) said that having a mental illness was harder for men while 6 (46%) thought women with mental illness suffered more. Social supports who thought mental illness was harder for men attributed this to men being expected to adhere to hegemonic stereotypes of masculinity and men with mental illness being perceived as dangerous. Those who felt it was harder for women attributed this to the fact that women experience gender based disparities regardless of mental illness.

Harder for men.

Judith: Yes, I really do [think it’s harder for men]. Because a man, and I’m not a man, I’m just saying the things that I think. A man don’t feel good when he can’t provide for his family. He don’t feel good when he can’t get a job and work. Earn enough money to support a family. He can’t really have a family. I’m sure that hurts a lot of Black men. A lot of Black men got to depend on their wives to get public aid to support their family. I’m sure a lot of men don’t like that. They would prefer to have a job and earn the money to support their family. But mental illness prevents them from doing that. So they just start drinking, staying out all night. All these things to try to comfort themselves.

Tabitha: Lord, yes [there’s a difference]. Because Black men are supposed to be strong. They’re supposed to project a certain kind of persona, you know, I’m a tough guy. I can handle anything that comes along. And mental illness says that there’s a weakness. And nobody wants to be classified as that.
Ada: Well I only know one lady, I don’t know what’s wrong with her, I don’t know if she’s schizophrenia…[She got on the bus], the lady got off in the wrong area, she didn’t see no Black people, she only saw White people, she started freaking out, took off her clothes, they called the police, took her to [the state hospital] where [her family] found her and [the hospital] released her to them. But I’m quite sure, in the manner of that, if that would have been my brother the situations would have been handled different. He probably would have been tased, then you would have taken him to jail, then you would have run his fingerprints like he killed somebody, made him sit there, we probably wouldn’t have known where he was, then you would have taken him to [the state hospital], then he would have sit there two more months before we even knew where he was, when it probably only took two weeks for her…They just treat men a little differently. Do I think they got it harder? Yes!

Harder for women.

Yvette: I’m sure there probably is [a difference]. Because women still aren’t treated equally in this area. I know they’re not, whether they are mentally ill or not. I think that’s gonna have to change too.

Quiara: If a man is mentally ill and lives on the street, he’s less likely to be abused. But a female, I don’t care what color you is, you on the street, living in a cardboard box, you can be raped.

Xarah: I think there’s a difference. I really do. Most females with mental illness, especially ones that won’t admit to it and not trying to get help, they get messed with. Sexual. They really do…Not too many mens will try and mess up with a male, but a
female…[trails off]. They take advantage of them because there is something wrong with them.

**Researcher Gender and Race**

As the participants and I discussed the role of race and gender in mental health care the conversation naturally turned to discussions of how race and gender influenced the research process and interview. While it was not part of my original interview protocol, I began to ask participants if they would have been more comfortable discussing mental health care for African American men if I were African American or a man. I was able to ask ten of the client participants and 17 social support participants.

The vast majority of participants, n=23 (88%), said that neither researcher race nor gender impacted their interview responses. When asked to elaborate, the two most common explanations given by all participants were that they felt comfortable with me and believed I was interested in improving mental health care and that they personally valued equality and tried to avoid discriminating against people based on race.

**Personal Rapport and Commitment to Help**

Sandy: No, I’m gonna talk to you the same way I talk to the sisters. You can kind of tell when you first start talking with [White people] whether they’re real or not.

Esther: We’re all people. That’s the way I feel. If you’re Black, ok, if you’re here for a good reason. If you’re White, and you’re here for a good reason, you’re welcome.

Zora: No, It wouldn’t make a difference if you were an African American. You would think more students would want to help, more African American students. But a lot of the kids today are going for the money.
Floyd: I ain’t got a problem with White or Black, Hispanic, whatever. You’re a nice cat.

Irving: I think most people, when you try to talk to most people. I think you all went to school to learn to conversate with somebody, because most of the people in the real world, they think I’m this handicapped person. So if I try to say something, like what I just told you what I want to do, they laugh and say, “You ain’t gonna succeed so if I was you I wouldn’t even think about it.” … It ain’t a race thing. It’s that person individual.

Personal Values

Ophelia: Can I tell something to you Ms.? It doesn’t make no difference what color it is, you hear what I’m saying to you? If it was White or Black, it doesn’t make a difference. It don’t make a difference to [him] and it don’t make a difference to me either. Cause whether it’s Black or White it should never make a difference on who gives you an interview… To me, it’s how you carry yourself in life. My mother and them, they raised me to help people in life, that’s what they done. And I believe in carrying that on in my life.

Karina: No because I don’t have any prejudice about who asks me questions and what answers I may give them because to me it’s all the same. We all bleed the same.

Violet: No, God always tells me to speak the truth. We all came from the same God. We’re the ones who think there’s a difference. We got the problem. So, that’s the way I see it. It would have been the same. Matter of fact I’m enjoying talking to you.
Carol: No, color doesn’t matter. Being a man or a woman, gay or straight. You have to face up to the truth. We all have problems and should be able to talk about situations.

**Reasons Not Comfortable with Interviewer**

Five participants stated that they would have interacted differently with me based on four factors. One cited racial differences, two addressed gender, one felt that having the same socio-economic status would be beneficial, and one noted simply that he was uncomfortable because I was a stranger. Though I asked participants about both race and gender most people simply ignored the reference to gender and exclusively discussed race as a factor. Only four participants specifically addressed gender. Two of the male clients stated they would have interacted differently or been more comfortable with male interviewers and two of the female social support participants thought that being a female would be beneficial for such interviews as people would feel more comfortable discussing private or emotional issues with a woman.

George: No, it doesn’t bother me. But you still would have been a stranger showing up and then I’m talking [about my brother].

Peter: No, ma’am, [I wouldn’t give you different answers] if you were a Black woman. Now if I was talking to a White male, Black male, I’d probably talk, like in way you don’t understand…talking slang…I don’t know, with a woman, a woman’s got things that a man wants. So I’m gonna come to a woman like that, I’m gonna talk to a woman like that, just let her come to me like that. But a man, I’m gonna say, “Come on let’s roll.”

Judith was the only participant to directly state she would have been more comfortable with an African American interviewer. She was also the oldest participant at 86 years old.
Judith: It would be more comfortable [if you were African American] because we’re working on the same level. Because your ideas are different from mine. That means you think different, you do different. You’ve come over roads that I’ll never come over, because you are White. There’s just no way, in some things we probably can think the same way, but in most, it’s not. Because I worked on a farm when I was coming up. You might never have worked on a farm, so that’s a different road right there. Because that means I had to get out there and work for eight hours. I had to be up at 5 o’clock in the morning to have breakfast, ready to be working in the field at 6 o’clock. Well, if a person has never done that, you can’t think like I think. You can’t. It’s no way you can think like I think because we’re not going over the same roads.

**Improving Mental Health Care for African American Men**

**Clients**

Participants were asked what CMHAs should do to improve mental health care for African American men. Clients’ main suggestion was that CMHAs should focus more on community outreach (n=14, 54%). Among those advocating community outreach the most popular suggestion was that outreach could be accomplished if staff and information left the CMHA and came to the “Black parts” of town (n=6) or that successful clients participate in outreach or programs so that they could share about their experiences in care and how services had helped (n=5). Three of the clients (12%) said CMHA staff needed to be more welcoming and friendly to encourage people to come and stay in care and nine (35%) had no suggestions for how to improve care.
**Community Presence**

Xavier: Staff need to get into the community. They might not feel safe but they can set up a place and time to meet people in the community. They can leave fliers around and call people on the phone to tell them about it. They could talk to Black women to get them to encourage their male family members to come in.

Norman: I would say have group meetings in different places, out into the community settings. You know something like a job fair, but in other words it’ll be community meetings all over different parts of the town.

Oliver: [African American men] will come in but sometimes you gotta go over there and knock on the door. Tell them you want to help them, come down to my office. Come down and talk to me. They’ll come down.

**Client Role Models**

Theo: I think if the government was to have some kind of organization that has some people that, you know, have went through a lot. Not only Black males but any other race. If they would have some kind of program they would set up and hire those guys that went through a lot trying to get help, I think it would encourage Black, White, purple, green or whatever people.

Interviewer: So you think hiring men who have been through a lot...

T: Or women.

I: so to run the program and be models for people?

T: Yeah, yeah, yeah.

Quinton: One way would be by us here with the illness telling our story and others hearing us. Let them know [the CMHA] isn’t bad. You got to give it a try, let it
work for you, make it work for you…They can learn, there’s a chance you can be blessed too. You got to follow through. Because it’s got to be known that they do good.

Brian: They need to show them that mental illness is not their fault, what resources there are available, talk to somebody that’s a role model. Get them into a Big Brother program. I was in a Big Brother program. I had an older friend who spent a lot of time with me when I was really suffering. That’s the main one right there. He did it for me and I want to do it for somebody else.

Social Supports

Social support participants also emphasized the need for more communication between the CMHAs and African American community: Eight respondents (31%) recommended CMHAs increase community outreach to potential clients, five (19%) stressed the need for more mental health education and collaboration with the families and communities of people with mental illness, and five (19%) felt that services needed to be improved or tailored to better serve African Americans or men. Of the remaining social supports four (15%) felt services could not be improved further and four (15%) had no suggestions.

Client Outreach

Louis: People would have to get out and find these people, get them off the streets. Cause they’re not gonna get any help. They’d rather stand there with their jug and drink, and smoke their little blunts, rather than to go get some help.

Zora: I think they could do better follow-up with patients. Instead of seeing them one time and if they don’t come back, just drop it. Maybe there should be a protocol for following up. Because if there’s a mental problem there’s a reason they’re not coming back.
Family Outreach

Nate: I think they should educate the families more so than what they’ve done. It’s not a disgrace. It’s not a shameful thing, not stigma on the rest of the members. You shouldn’t shun them or run from them or be ashamed, you know how a lot of these people are. And they want to dump them somewhere and get rid of them and they want to go on with their business. And I don’t see it that way. They think it’s because you associate with people who are sick, you are included, you’re one of them. That’s the stigma some of them seem to have.

Ada: A lot of people are scared of counseling. Maybe if counseling had been available for the homes and Black women knew about counseling, and I’m gonna say Black women because they’re the ones that bear the children. If we knew how to go about, once we see a change, asking them what’s bothering them, what’s wrong…Why not educate us too about what can happen if your child is not healthy. Cause people never told me when I first learned that I was pregnant they just worried about me getting the right nutrients and the right state of mind, don’t be stressed so you can carry your baby full term. They never once warned me, hey when your daughter get of age she could be schizophrenia if there is schizophrenia in your family.

Specialized Services

Preston: I think one would be to have more mental health counselors who are Black. I think sometimes we have a tendency to trust or open up and talk to someone who is similar. I think that men don’t share as much as women do. So I think that the personnel will have to be more aggressive or, we can’t get all this done in one or two visits. It
might take more. Because many times as a male we’re not going to open up as quickly as a female would.

Ross: If they would get them in there and teach them something, try to learn them something like reading or simple math. You know, some of them can, but you know that’d be a start because if you got that you can make it in the world. And that’s what I think, they should really teach them something when they go down there. Not make them sit there and then make them bring their own lunch. I mean, it’s done went to nothing down there.

Reported Causes of Mental Illness

Clients

Clients and social supports were both asked what they believed caused the client’s mental illness. Clients provided a variety of explanations for their mental illness: situational stressors (n=12, 46%); genetic propensity (n=3, 12%); physical injury such as head trauma (n=3, 12%); abuse of alcohol or drugs (n=2, 8%). Additionally four clients (15%) were unsure what caused their mental illness, and two (8%) asserted that they did not have a mental illness or disagreed with their diagnosis.

Situational Stressors

Vincent: I think what caused my mental illness was because of the loss of my wife, family members, kids, and other people dying in my life.

Norman: I’m gonna say, number one, when I was in high school I had to raise my siblings under me. And they was, all together it’s 13 of us, but eight of them under me. And during high school you can imagine all the little ones that was under me. I had to raise them because parents was at work. Mom had her own personal job. Dad had his
own personal job. I had to get them up for school, do this, do that, make sure everybody go to school, I’m the last one to go to school. I have to come home from school, come straight home from school. I had to play the dad because mom and dad didn’t get home till six or seven in the evening. I was there from the time I’m out of school at 2:30. I gotta get back then make hot dogs and pork and beans because that’s all I knew how to do, until mom and dad got home. I’d never had a childhood because I was the dependent person for my sisters and brothers. The other three were gone, on their own. I had to be that father and mother until mom and dad got home. So, with all them different personalities plus me trying to squeeze in some childhood and be a child myself, I think that all had a combination of doing it. Too much stress. Nothing else besides there were alcohol and drugs, substance abuse. I was using that as a release.

Sully: People not paying me back, taking my money, that’s what’s causing my mental illness. What else causes the mental illness is people yelling at me and telling me to shut the blank up.

Irving: I think that my mental illness it came from me not having a real father figure to point me in the right direction. I had a lot of stuff from my uncle. But I just needed [my father], in a bad situation.

**Social Supports**

Social supports identified a similar set of possible explanations as the cause of mental illness but were less clearly grouped around one explanation. Social supports identified the
sources of client mental illness as poisoning such as being “slipped a mickey”\(^1\) (n=6, 23%); situational stressors (n=5, 19%); genetic propensity (n=5, 19%); a combination of genetic and environmental factors (n=2, 8%); and head trauma (n=1, 4%). The largest group of respondents were social supports who stated they had no idea what caused their loved ones’ mental illness (n=7, 27%).

**Situational Stressors**

Yvette: [His mental illness] was caused by what happened in Vietnam. He was a Marine and in Vietnam and he described seeing people on fire. And he said nobody should have to die that way. And it was some of his guys from his platoon. I think that really had a lot to do with it. Some of the things he told me were just so bad.

Irene: I do know from talking with him that family had a lot to do with it. Things that happened in the family had a lot to do with it. So I guess I’d have to say from what I’ve heard probably family issues are what started it. It may have been deeper seated than that but it’s what brought it to the surface.

Tabitha: Maybe feeling that he was different his whole life, you know, being gay. And he wasn’t sure how to handle it or how to channel the feelings. You know a lot of times I think other kids pick up on it long before parents see anything and they might have teased him.

**Slipped a Mickey**

\(^1\) The term “slipped a mickey” originated in Chicago in reference to a local bartender, Mickey Finn, who surreptitiously drugged his customers in order to rob them (Asbury, 1940). In interviews the phrase was used to describe any incident where a person unknowingly consumed a drink that had been laced with a drug. The intent of drugging was to cause harm though not specifically robbery as in the original usage.
Violet: He got hooked to some PCP…He likes to dance, he likes to party, but somebody put something in his drink. That’s what the doctor told me…He has two kids. I think the oldest son is about 22 and [the daughter] is about 19. I saw her this morning. Something’s going on with her. They slipped her something. It’s really going on with her.

Xarah: Well I’ll tell you what my son told me when he came back from Atlanta. He said he met this girl…And when he came back, he took me to the park and said, “I need to talk to you.” I said, “Ok, what’s going on?” He said, “Me and her used to get into it all the time and she took me around a witch.” I said, “What!” He said, “Yeah, I was sitting there and this witch gave me something to drink and something wrong with me up in here.” Now that’s what he said, “Something is wrong. I think she had me witchrafted because I started to find out she wasn’t the right one and I was getting ready to leave her and stuff.” And he said, “I’m just sitting up there talking and stuff and all of a sudden the woman said, ‘I’m a witch. I’m a witch doctor.’” And he was already drinking whatever they had gave him. He said, “I think they put something in my drink. I don’t feel right up in here.” And about a year later he started deteriorate…I heard it a lot from the generation before me. I heard it growing up. I heard a lot of people say, “I was witchrafted and had to get delivered by a minister.” But I done heard it before that somebody can slip something in your drink.

Quiara: Ok, I’m gonna tell you what happened to [him]. [He] went out to a party and he was with one of his best friends. They went to this party and somebody slipped a mickey in his drink and that’s when the problems started. After they did that I started noticing change in him…He said he went to the bathroom. He told his best friend to
watch [his drink] so I’m thinking his best friend had something to do with it too, because of a female. The female that [the client] was dating. His buddy started dating her too and they was trying to keep it a secret…I’m like, ok, I can’t put my finger on you but until she ever lets it slip out her mouth that she was the one that did it, which she has not to this day, ain’t nothing I can do. [The client] tells me, “I know she did it.” But then I’m thinking about his best friend. Your best friend was right there and nothing happened to him. Why did he set your drink down for somebody to put something off in it? Did he have anything to do with it? And I’m thinking it was all over a girl.

Interviewer: He never got better though, when it wore off?

Quiara: It never wore off. I don’t know how much he had in his system. I mean it just unbalanced him. And to this day, you know, he’s focused now, but for how long? What will trigger him off?

One of the social support participants no longer believed her brother’s mental illness was caused by being slipped a mickey but she explained how she had initially believed that scenario. She noted that being slipped drugs or experiencing brain trauma were popular explanations for adult onset mental illness.

Ada: I found out a lot of things through that [meeting with the mental health provider]. It wasn’t a class for me but I just sat in. I wanted to know and I took my time to find out. But I really thought someone had mickied my brother so it upset me. Not that I was racist or anything but he had been going with bi-racial women and, one of the young ladies, her father did not care for my brother…We didn’t understand how you go from graduating from barber college to like a week or two being schizophrenia so we thought maybe her father mickied or did something to him. It’s a common thought.
Nobody tells you nothing different. Nobody offers the family support or help to figure out what is the cause or what is the matter. During that period of time, like I say, he had just graduated from barber college. My brother never seemed to think or to act out like something was wrong with him. He always was more aggressive if somebody made him mad, that’s because he never got into things. My brother was no bad brother. My brother he had groups he was with, he had a whole bunch of friends, he was known. People liked my brother. So it was like, to me, when this all occurred all in one month, you want to know, “What happened?” Literally, people think that people mickied him or that he got into some accident and maybe he had a brain aneurism that he suffered from. The number one answer is that they were mickied. And when I sat in the class I quite didn’t understand…so after I sit in, and [the clinician] diagnosed him with being schizophrenia I did my own research to find out it was hereditary. And she said it’s a gene that come from you don’t know what side of the family, who it’s from, but a lot of time it comes out at an age 24, 25, and then they start acting weird. And so people want to say it’s from being mickied because they don’t want to think nobody in their family is crazy.

Policy and Funding Impacts

For several years prior to data collection both of the states where interviews took place experienced significant cuts to their mental health services funding (Larrison, Hack-Ritzo, Koerner, Schoppelrey, Ackerson, & Korr, 2011). As part of the interview process I discussed with client and social support participants how the client paid for care or had paid for care in the past and if they were worried about how funding cuts would affect quality and quantity of services.
Clients

The majority of client participants (n=16; 62%) were not concerned that services would be negatively affected, though six of them noted that they were not worried because they had payees or guardians who oversaw their financial concerns.

Lance: Yeah, that stays on my mind daily. How would our income be? Will they go up on medications? All of that, that’s got me worried…This [CMHA] might not even be here. You just don’t know. They would close for lack of funds. I’m praying every day. They say [the state hospital] is under that pressure too.

Quinton: At first I didn’t know how they do it, it’s the medical card, but it do cost. But I thought well, they say I’m good, so I went on. And then I learned not to take advantage of the situation. I learned they were helping me. I was thanking the Lord, because sometimes people do have to pay, you know, literally out of their pocket. That’s why a lot of clients, some clients, they don’t attend classes and things because it costs them literally. I was glad, because I appreciate that, because I know one guy, I said, “You going to class?” and he said, “No, I can’t afford it.” That’s several clients like that. I guess I’m privileged, to be able to take classes and not have to pay.

Norman: Now they talking about cutting Medicaid out. That is gonna hurt so many people. Yes, I worry as far as my medication. I mean it’s hard enough paying rent and getting personal things out of a monthly pension. Trying to live.

Social Supports

Social supports were evenly divided between concerns about future funding of community mental health care (n=12; 46%) and confidence in the system (n=12; 46%). Another two (8%) respondents were unsure about future funding and services.
Ophelia: Well, I’m gonna say this to you, I worry about really everything. I worry about all these jobs they really trying to cut out, cause it’s gonna hurt lots of families…My very good friends, they work at [the state hospital]. They even talking about closing it down. And then where are the patients going? See they don’t need to be behind bars and stuff like that, that ain’t right in life. So I feel there’s a whole lot that I could say that I don’t think is really right. And I feel that people got to fight to keep them from closing down stuff.

Carol: Through what they give you through Social Security I doubt if he’d be able to live and get a place of his own and then pay for mental health care. No, I don’t think he’d be able to do that. For what he gets a month there’s no way he can get a house or apartment and take care of everything and then pay for it too. There’d be no way. There’s nobody to take him in or help him. Everybody’s struggling they self. I heard somebody telling me about that, that the state is getting behind on money and stuff like that. It just gonna make matters worse.

Louis: Well he’s got a medical card, like I do. If they ever take his medical card away from him he’d be like me, he’d be lost. [The state’s] already cutting back. That’s already been done. Medicare. They cut back on child care. A few things. [The program my brother attends] their talking about cutting back on it. The youth camp, they’re shutting it down.
CHAPTER 5

DISCUSSION

This chapter explores the implications of the findings presented in the Results chapter for African American men’s mental health care. The three initial research questions are revisited and unexpected findings are also discussed. A theoretical model describing the impact of social support network exclusion from mental health care on clients and rural communities is presented. Finally, the chapter closes by acknowledging the research study limitations.

Research Question One

What client factors contribute to rural African American men with serious mental illness (AAM-SMI) engaging successfully in ongoing mental health treatment? Among the men in this study, positive mental health outcomes for African American men were influenced by client perceptions of social support engagement in mental health care.

Pre-study quantitative analysis found that in the original sample African American men who left treatment (N=35) and those who stayed (N=41) did not differ when compared across diagnosis, BASIS scores over three measures, payment source, medication use, work or volunteer activities, age, evaluation of provider cross-cultural skills, and satisfaction with services. The only identified difference was that African American men with serious mental illness who stayed in treatment were more likely than African American men with serious mental illness who left treatment to report that they had family support (p=.09) while those that left were more likely to report they had no social support at all (p=.10). Qualitative interviews with the clients confirmed that the men had significant and active social support networks. The importance of social support networks and family contact for African Americans with mental illness has been confirmed in research (e.g. Guada, Hoe, Floyd, Barbour, and Brekke, 2012),
which found that the “amount of family contact had significant positive relationship to consumer psychosocial functioning” among African Americans with schizophrenia (p. 52). However, research focusing on social support generally does not examine the details of social support interaction, such as differentiating between received social support and perceived social support or clarifying the arenas in which social support occurs such as the family, community, or community mental health agency.

The men in this study reported numerous sources of both problem solving and nurturant support and half the men (n=13) reported that in addition to their interactions with social support members in their daily lives a member of their social support network was involved in their mental health care. However, interviews with primary members of the men’s social support networks revealed that only five social supports actually reported having contact with mental health providers and discussing client mental health care. This discrepancy indicates that clients do not strongly differentiate social support network involvement in their everyday life from social support participation in client mental health care and that this perception of engagement in mental health care may be as beneficial to clients as actual social support participation.

When clients were questioned about what activities or conversations indicated that social supports were involved in mental health care, they provided vague responses or one-time examples. For example, Theo equated his son or sisters giving him a ride to appointments or helping to pay for medication as involvement, and Brian reported his mother’s participation, though he knew she did not utilize the release of information privileges he had given her. Inaccurate assumptions were not limited to client perceptions of social supports but rather were pervasive throughout the client, social support, and CMHA systems’ interactions around mental health care. Social supports were hesitant to push CMHA staff, or even clients, about
information and treatment involvement and CMHA staff appeared to assume social supports were absent or uninterested. In the interviews with social support and client participants it was clear that clients had social support systems in place and neither social supports nor clients were hesitant to discuss private, difficult, or emotional topics. The client, social support, and CMHA systems are all operating in the culture of the larger community, which social support interviews confirm is rife with stigma and stereotypes about mental illness. This environmental influence may make social supports more likely to acquiesce to perceived signals that they should not be involved in care and may encourage CMHA staff to label social support networks as unhelpful.

Despite these hesitations and miscommunications, when clients were asked if social support involvement had been beneficial to their mental health, 92% (n=12) said yes it had been. The men in this study experienced psychosocial benefits from social support in their lives and those who perceived social support involvement in their mental health care welcomed and positively evaluated it. Considering these beneficial outcomes, social support participants’ reports of being hindered when attempting to engage with community mental health agencies should be considered in an even more negative light. Failure on behalf of mental health providers to collaborate with social support networks does not only frustrate social supports but may deny clients additional advantages.

**Research Question Two**

*What social support factors contribute to rural AAM-SMI engaging successfully in ongoing mental health treatment?* The presence of a varied, non-staff based social support network was beneficial.

Interviews with the clients confirmed that the men had significant and active social support networks. Even though the men all had serious mental illnesses, the size of their social
support networks was similar to those of Black people without mental illness (Ajrouch, Antonucci, & Janevic, 2001). The average number of people in clients’ networks was 7.4 (SD=4.5). Ajrouch, Antonucci, and Janevic (2001) surveyed 131 Black men and 244 Black women aged 20–93 in order to describe their social support networks. They found that among Black participants the average network size was 8.3 (SD=4.7). In this sample, immediate family such as parents and siblings comprised the majority of the social support networks and were also the primary sources of enacted support for clients. Approximately half of clients also reported having friends and extended family members in their close networks. The fact that 23 of the first social supports contacted agreed to be interviewed further demonstrates the close relationships between clients and social supports and the social support members’ investment in assuring quality care for the clients.

The variety of people and relationships represented in the social networks allowed the men to draw different types of support from multiple sources. For example, Xavier described a social support network consisting of immediate and extended family, friends, a CMHA staff member, and members of his church community. He described interactions with these people which included sharing emotions, receiving tangible support such as meals and rides, going fishing, discussing spirituality, and hanging out. While people such as his mother, two close friends, and his case manager were frequently mentioned, none of them were relied upon exclusively for specific types of support.

**Relations between Social Support Networks and Community Mental Health Staff**

Xavier’s interactions with his social support network were typical among the men in this study and contributed to positive psychosocial outcomes. From the perspective of the network, the size and capability of client social support networks did not seem to be recognized by CMHA
staff. In addition to social support participants’ own reports about the difficulty of communicating with mental health providers, comments from staff members illustrated that staff may not see social support networks as viable collaborators for addressing client needs. Both Yvette and Franklin did not believe that social support networks were available to clients and Franklin reiterated twice that he didn’t believe that family understood or cared to learn about client mental illness. These opinions echo findings from Biegel, Johnsen, and Shafran (1997) who found in a focus group with case managers that staff doubted families’ ability to provide support due to “personal traits of the caregiver, such as an unwillingness to acknowledge the mental illness of the family member or the caregiver’s own mental illness, or from structural impediments, such as poverty and lack of education” (p. 169). Support network maps and both client and non-staff social support interviews indicate this is not the case. Family and friends were more prevalent in client social support networks than staff and viewed by clients as greater sources of problem solving and nurturant support than CMHA staff. Non-staff social supports were generally willing to be involved in mental health care to whatever extent would be helpful and welcomed by the client. Cohen, Drapalski, Glynn, Medoff, Fang, and Dixon (2013) also found similar enthusiasm for social support involvement among a larger sample of predominantly African American male consumers with serious mental illness. “Seventy-eight percent (171 of 219) of the consumers wanted family members to be involved in their care, and many desired involvement through several methods” (p. 257).

The attitude that the onus is on family and friends to pursue information and demonstrate to mental health providers that they are knowledgeable is problematic because it exacerbates barriers to care. It is understandable that overtaxed CMHAs are hesitant to expand into extensive family education, however in their review of family-based services for people with schizophrenia
Dixon, Dickerson, Bellack, Bennett, Dickinson, Goldberg, et al. (2010) found that as little as four sessions focused on collaborative decision making, education, training, and support resulted in positive psychiatric and relational outcomes for both consumers and families. There are also several well established family education programs that provide the framework and curriculum for volunteer-run family education. One of the most well-known is Family-to-Family, a program operated by the National Alliance on Mental Illness (NAMI), which is a free 12 week course taught by family members of people with serious mental illness. Dixon, Lucksted, Medoff, Burland, Stewart, Lehman, et al. (2011) conducted a randomized study to evaluate the effectiveness of the Family-to-Family program with 318 participants. They found that compared to family members not in the program participants experienced significant improvement in empowerment, illness knowledge, problem solving skills, acceptance of family member illness, and decreased distress. New York State utilizes a Family Peer Advocate program modeled after the consumer peer educators programs often used in community mental health care. Rodriguez, Olin, Hoagwood, Shen, Burton, Radigan, et al. (2011) found that family participants felt more empowered working as a Family Peer Advocate and devoted the majority of their time to offering emotional support and helping families to engage with the treatment system via activities such as providing information about resources, legal rights, and preparing for provider team meetings.

These programs mesh well with the participant suggestions for improving mental health care for African American men. Five social supports (19%) felt that programs aimed at educating and working with families of clients would be helpful. The main recommendation from both clients (n=14, 54%) and social supports (n=8, 31%) was that CMHAs needed to be more present in the community via conducting outreach to clients. CMHAs may find
sponsorship of and collaborations with NAMI chapters as a viable way to increase their presence in the community without committing significantly increased staff time. However, reliance on programs such as NAMI should not be seen as replacement for CMHA involvement. The overall message from participants was that CMHAs should be a more integrated part of the community so CMHAs must be prepared to exert themselves to be more visible.

**Research Questions Three**

*How do race, gender, location, and social support contexts interact to influence treatment experiences?* In discussions of prejudice and disparities, a minority of participants (38%, n=20) felt that race negatively impacted mental health care experiences and approximately half reported (46%, n=24) that gender impacted care negatively. Considering the impact of community and location, 46% of social support participants (n=12) felt that the broader community viewed mental illness negatively and 54% (n=14) specifically thought the African American community did not understand mental health care and were hostile toward people with mental illness. Despite living in communities of less than 50,000 people, the majority of social support participants (62%, n=16) had no or extremely limited knowledge about their community mental health center and its services.

**Race and Location**

Racial and gender disparities in mental health care treatment are well established (DHHS, 2001; Lowe, 2006; Snowden, 2001; WHO, 2009). Therefore it would not have been surprising if a majority of participants reported experiencing disparities or even expressed concern or doubt about the equality of care provided to the African American men in this study. However, the majority of participants, 16 clients and 16 social supports (62%), reported that they did not believe mental health care was affected by race or were not certain either way. Ten clients
(38%) and 10 social support participants (38%) believed that disparities existed between how White and African American clients were treated in mental health care: Clients who felt disparities existed were unanimous that African Americans were discriminated against while social supports mostly supported this view but also considered the moderating effects of poverty on race. When explaining racial disparities participants cited examples of microaggressions against Black clients that resulted in privileged treatment of White clients. This included assertions that Black clients had to wait longer for services or that staff reacted more punitively to Black clients transgression of rules.

The preponderance of literature discussing perceived racial discrimination and mental health focuses on clients’ appraisal of racial discrimination experienced in their daily lives and how this impacts their overall mental health or trust in mental health providers. It is therefore difficult to establish what percentage of clients typically perceive discrimination within care or from providers. Hausmann, Jeong, Bost, and Ibrahim (2008) analyzed the 2004 Behavioral Risk Factor Surveillance System to understand patient perceptions of discrimination in health care settings and found that 10.9% of the 5927 African American patients reported discrimination, the highest rate among any racial group. This context would indicate that the number of study participants reporting racial disparities in this study may actually be high.

Examination of participant opinions found that those reporting disparities were primarily clustered around two communities. According to the U.S. Census State and County Quick Facts (n.d.b), of all the sites in this study these two communities had the highest percentage of African American citizens and had the lowest median household income. The National Rural Health Association (2008) reports that rural areas have significant problems attracting and retaining behavioral health specialists to their areas. Communities such as the two where disparities were
primarily reported may have even greater trouble attracting and retaining staff to live there as they may be seen as poor or dying communities. While this interferes with the ability of CMHAs to provide services, it may also exacerbate racial and socioeconomic conflicts between staff and clients by creating a community of people who cannot leave the area, served by staff who come into the community only to interact with clients facing significant mental health and life issues. This very issue was brought up by a staff/social support participant and a client participant in one of these economically depressed communities.

Lance: They was saying, “Always look on the bright side of things.” I’ve said, “I’ve always looked on the bright side of things” (laughs). But just taking a look at the environment I’m in. You know some of them over there [at the CMHA] they probably see it just briefly, just during the time they work here and then they go back to their beautiful homes and uplifting places, you know where they live at. I’m still down here in this rut.

Franklin: A lot of the staff are local but very few live in [the community]. We have quite a few staff that live in the surrounding area and I’ve lived [in a town 45 minutes away] for 25 years. It’s hard to say because there is poverty there and in my opinion, I mean it’s not gonna change. I mean it’s there and it’s just gonna go downhill. But that’s not our job to deal with that, we just deal with the side effects of all that stuff.

Across the sample significant numbers of client and social support participants did not report racial disparities, which is a positive indicator of the quality of care provided by CMHAs. However, it appears that community environment, as a variable separate from CMHA organizational characteristics, can interact with race to aggravate feelings of racial discrimination and mental health care disparities. This factor should be considered in future research examining
treatment disparities or within-agency discussions about providing quality and equitable care.

**Gender Differences and Hegemonic Masculinity Socialization**

While clients and social supports were more likely to believe that gender differences existed compared to racial differences this may have been the result of having more “acceptable” options to pick from: While it is highly unlikely that a person would report that White clients experienced negative differences, it would not be uncommon for a person to feel that either men or women could experience disparities in care. Regardless, participants’ perceptions about whether men or women with mental illness were disadvantaged, the opinion was generally grounded in hegemonic masculinity norms. Clients and social supports described societal expectations that men would be stronger, tougher, and uncomfortable asking for help while women were seen as more emotionally aware, held to higher societal standards of behavior, and vulnerable to sexual assault. Some participants noted how these gendered stereotypes hindered men from getting assistance because they were seen as more dangerous or more likely to be problematic clients.

These assertions match what has previously been written about cool pose, Majors and Bilson’s (1992) theory of hegemonic masculinity socialization among African American men. Majors and Bilson (1992) wrote, “Coolness means poise under pressure and the ability to maintain detachment, even during tense encounters…People are drawn to the power of the cool black male because he epitomizes control, strength, and pride. He presents a mysterious challenge. He is charismatic, suave, debonair, entertaining” (p. 2). Using this lens to interpret the comments from participants provides additional detail in understanding the quotes. Gender socialization requires men to internalize the stereotype of masculinity. Thus, they must act with or against these definitions when confronting mental illness. However, as the previous quote
about cool pose describes, the definition of cool pose is not just individual performance but also how others react to and are attracted to the individual. Therefore, rejection of stereotypically masculine responses to mental illness is not simply an internal battle in which participants must choose how they define masculinity but can also create conflict between the individual and the community. Male clients cannot control how the community will choose to react to their rejection of a cool pose identity and thus cannot prevent negative repercussions. This is not an ungrounded fear. As indicated by social support interviews, the communities and African American communities the men are located in do not respond positively to perceived mental illness or mental health treatment.

The cross-gender negative effects of these stereotypes presents an opportunity for community mental health agencies to conduct broad community outreach. Agencies concerned about using their limited staff and financial resources to address stigma may view efforts challenging gender stereotypes as applicable to large areas of the community. The use of targeted educational materials or public service announcements in outreach efforts was also mentioned in participant interviews. Joshua suggested an explicit approach to advertising, “They could put up a flyer and say [they want more African American men to come to services]. They could put it in the [newspaper].” And Douglas said, “If you had a census of how to get in touch with them in the mail. Some people, they don’t want to actually have to walk into an office to fill out a survey or whatever but I think if they maybe had a pamphlet or something that came to them in the mail…”

For within-agency staff focused discussions of how to reduce differences and better meet the needs of underserved populations, gender may be a more comfortable starting point. In van Ryn and Fu’s (2003) model demonstrating how public health and human services providers
contribute to racial disparities in care they acknowledge that many providers unconsciously create disparities and that addressing provider factors is often uncomfortable and difficult because providers view their actions as having good intent. While protecting staff from uncomfortable conversations should never be a priority there may be a benefit to “meeting people where they are at” starting with gender discussions and progressing into more difficult conversations about racial disparities in treatment.

Social Support Contexts and Mental Health Services

The Network Episode Model (Pescosolido & Boyer, 1999) conceptualizes treatment experiences as the interactions between individuals, social support systems, the illness career, and the treatment system. Social support systems are understood as part of the community structure and, of course, as producers and receptors of community attitudes and beliefs about mental illness. Using this model as a lens with which to analyze participant interviews, a specific cycle of multi-system interactions heavily involving the social support networks became apparent. Community knowledge, social support involvement in mental health care, and stigma about mental illness combines in the rural communities where data was collected to create a pattern that hinders African American men and their social support networks from fully benefitting from mental health services. Figure 6 illustrates the theoretical model developed from interviews with clients and social supports about their knowledge of community mental health services, experience with agencies, and the overall impact on the community.
Only six social supports (26%) reported that they were aware of the community mental health agency prior to the client receiving care and had positive opinions of the agency. Most, (n=16; 62%) had no knowledge of the CMHA or knew it existed but did not understand what services it provided. As a result, social support networks did not have the knowledge necessary to refer the men to mental health care when they began to exhibit signs of mental illness. Instead, social supports reported that the clients originally entered mental health care due to professional referrals from people such as school staff or doctors or entered care after police
intervened when clients became disruptively psychotic. Once symptoms became too pronounced to be ignored and clients entered care at their community mental health agency there was broad failure to communicate or collaborate between staff and social support networks. This resulted in the agency unintentionally making themselves solely responsible for insuring clients attended appointments and followed their medication regimen. Clients who are satisfied with services, acknowledge they are benefiting from care, or who develop friendships with staff may continue to utilize the CMHAs, but those who want to leave have less incentive to stay since they face limited or non-existent push back from friends and family. Regardless, if African American male clients exit or stay in care, social support networks who are shut out of the CMHA remain in the community and do not offer any counter effect to stigma or lack of knowledge about available resources about help and treatment.

If acknowledged, this cycle has the possibility of being interrupted. For example, social supports indicated they were hesitant to push involvement in their loved one’s mental health care because they perceived staff as gatekeepers or wanted to respect clients’ right to privacy as adults. However, an open, team-based approach to care in which providers, clients, and social supports meet and work cooperatively helps overcome both these concerns by signaling client and staff openness to family involvement. Pitschel-Walz, Leucht, Bauml, Kissling, and Engel (2001) conducted a meta-analysis to understand the relationship between family involvement programs and worsening of symptoms or rehospitalization among people with schizophrenia: They found that “the relapse rate can be reduced by 20 percent if relatives of schizophrenia patients are included in the treatment. If family interventions continued for longer than 3 months, the effect was particularly marked” (p. 73). In addition to improving individual African American men’s mental health care experiences, social support involvement in discussion of
treatment interventions and concerns would increase the number of educated informants in the community, possibly resulting in a decrease in stigmatization and an increase in referrals.

**Unexpected Findings**

In qualitative research themes often emerge that were not expected in the initial hypothesis. In this study an unexpected finding that emerged were beliefs about the causes of mental illness. While there is no one answer to the origin of mental illnesses the National Institute of Mental Health states there are “genetic, neurobiological, behavioral, environmental, and experiential factors that contribute to mental disorders” (2008, 2). The clients in this study primarily asserted (n=12, 46%) that stressful life experiences had caused their mental illness and were equally likely to cite genetics (n=3, 12%) as they were to report that their mental illness had been caused by injury resulting in traumatic brain injury. Though the theme of physical trauma presented in both client and social support groups, none of the clients were being treated for Axis III disorders

Of most interest were the responses from social support participants. Social supports identified being slipped something in a drink as the cause of their loved ones mental illness (n=6, 23%) almost as often as they reported not knowing (n=7, 27%) or genetic factors or a combination of genetic and environmental factors (n=7, 27%). The social supports in this sample had long-term relationships with the clients and for the most part had known the clients during the entire course of their lives prior to mental illness and during diagnosis and treatment experiences. Despite being highly invested in the clients’ lives and mental well-being the prevalence of the first two responses among social supports, no explanation for the mental illness or outside evil influence, illustrated how overwhelmed and confused social support are by the nature of mental illness. Ada confirmed that being slipped a mickey or experiencing head
trauma were common explanations for mental illness in her community. She herself had only rejected the idea that her brother had been slipped a mickey after being allowed to observe a session between her brother and a mental health provider, hearing the therapist’s assertion that schizophrenia has genetic roots, and conducting her own online research. Ada was lucky and persistent enough to have the opportunity to interact with her brother’s mental health provider even though no opportunities for family-focused meetings were provided and this was the only reason she amended her beliefs about mental illness. Ada was no different than most of the other social supports who participated in this study. She was not closer to her brother, more involved in his day to day care, or possessing of more previous education or knowledge. She simply had an interaction with her brother and his provider that offered her a plausible explanation from a professional authority. It is a common narrative across cultures that an outside malevolent force may be the antecedent of madness (Bever, 2000). It appears that without alternative explanations from a trusted source some social supports understandably returned to this theme.

A search of research literature related to being slipped a mickey did not reveal any direct references to this explanation but did identify articles discussing similar rates of other esoteric mental illness explanations, such as evil spirits or punishment from God, among African American participant samples (Compton, Esterberg, & Broussard, 2008; Esterberg & Compton, 2006). A general online search found references to the connection between developing a mental illness and being slipped a mickey on two Chicago-based, African American focused websites (Mingle City, 2010; ONE, 2012). Also of interest to note is that the term “slipped a mickey” originated in Chicago (Asbury, 1940). Due to the geographic specificity in online references to being slipped a mickey, the historical origin of the term, and the location of research participants
in Midwestern communities, the explanation that slipping a mickey causes mental illness may be a Midwestern variation of traditional esoteric explanations.

**Limitations**

The limitations of this study are the sample size and the lack of a comparison group of African American men who left mental health treatment.

The sample size of 26 subjects per participant group is sufficient for qualitative analysis and well suited to the in-depth exploratory nature of this research project. However, as is the case with all qualitative research, the small sample limits the generalizability of the findings (Bailey, 2007). Though we cannot broadly apply these results to all African American men with serious mental illness or their social support networks, we can use findings from this project to develop research questions, hypotheses, and targeted data collection in larger samples and create pilot intervention studies.

This research examines characteristics of social support that contribute to positive engagement with mental health care. However, the research solely focuses on the experiences of men who have reported satisfaction with mental health care. This study does not offer analysis of differences between these men and those who were dissatisfied with care and left treatment. Comparison between the two groups could not be conducted because of the difficulty of locating and enrolling such clients in the study. In the parent study the men who left treatment generally did not maintain the same residence or phone number and were not available for further participation. Therefore attempts to locate and enroll these participants three years later would have been extremely difficult. Though a comparison group was not used, interviews and social network maps were analyzed for commonalities among the men who stayed in treatment and their social support networks in order to identify characteristics of successful clients.
Despite these limitations, the methods employed in this study were the best approach for this stage of research. Previous data collection conducted under the Climate, Diversity, and Outcomes in Rural Mental Health research project focused on broad quantitative data collection that yielded a large sample. This data has been thoroughly analyzed using statistical analysis and could not yield further in-depth findings. In addition, since data collection began in 2007 the members of the research team, including myself, had had ongoing interactions with participants, resulting in a level of familiarity and trust between the participants and the researchers. Therefore, using qualitative interviews to gather thick descriptive data was a particularly apt choice for the next stage of research.
CHAPTER 6

CONCLUSION

This study used qualitative interviews with rural African American men and members of their social support networks to describe and understand how the men and their networks interact with each other and the community mental health system and how those relationships impact mental health care experiences. The study found that though clients viewed social support networks as involved in mental health care the majority of social supports were excluded from the mental health care system. The primary barriers to social support network involvement in mental health care were unexplained confidentiality restrictions and social support efforts to support client independence. While clients were predominantly pleased with services the impact of social support exclusion from mental health care treatment was evident in social supports’ dissatisfaction with services, ambivalence about medication compliance, and lack of awareness of CMHA services. Client and social supports suggested that community mental health agencies could attract more African American clients and increase retention by conducting more client and family outreach in community locations outside the CMHA.

When asked about the etiology of their mental illness clients predominantly cited situational stressors; social support networks had a greater array of opinions about illness origins including a belief that covert drugging resulted in adult onset mental illness. Perceptions of racial discrimination in care appeared to be associated with community characteristics while perceptions of gender differences were related to societal gender-specific stereotypes. Despite some negative perceptions of race and gender disparities participants largely reported that they were comfortable being interviewed by a White, female researcher because they believed the researcher was genuinely interested in improving mental health care for African American men
and because they espoused personal values of non-discrimination. In relation to funding cuts for mental health care services roughly half of clients and social supports were concerned that state budget restrictions would lead to facility or program closures.

Implications for Mental Health Care

The results of this research indicate the need for community mental health agencies to move beyond the limited provider-patient dyad and conceptualize services in a manner that recognizes the reality of clients’ lives. Regardless of staff assumptions, clients do exist in the context of a social support network that provides resources, advice, and emotional support. Clients and social supports are interested in social support engagement in mental health care and are waiting to be shown how to productively participate in the treatment system. CMHAs should set goals for a minimum number of family consultations per year, where staff, clients, and social support network members meet together to discuss concerns and treatment plans. Many clients at CMHAs use Medicaid or Medicare as their payer source and billing codes for exactly such meetings already exist, ensuring that collaborative meetings are not discouraged out of fear of lost billable hours (Santa Clara County Medical Association-Monterey County Medical Society, n.d.).

In addition to family collaborations CMHAs should also increase their presence and activities in the community. Mental health agencies that wish to address racial and gender disparities should work to be seen as a part of the community network of healthcare and social service, not a separate and independent entity. If mental illness and what occurs in mental health treatment is a mystery to most community members this lack of knowledge will only continue to serve as a barrier for potential clients needing assistance and nurture stigma. As suggested by clients, targeted mailings, newspaper advertising, or public service announcements would also be
a good initial effort to raise CMHAs’ profile in the community, increase awareness of services, and decrease stigma. Collaborating with social support networks is the first step toward greater transparency but CMHAs should also look for community partners that will create opportunities for staff to interact with the public and provide materials and information about mental illness and mental health care: Such possible settings where CMHAs could increase their visibility include churches, schools, community celebrations, and health focused events.

While this research focuses on how CMHAs can improve the services they provide, these recommendation are less likely to be enacted without sufficient commitment on behalf of state and federal governments to funding and policy support for mental health care. Long underfunded, community mental health agencies have faced devastating budget cuts and delays in payment in the last several years and as a result have been forced to cut staff and services (Larrison, Hack-Ritzo, Koerner, Schoppelrey, Ackerson, & Korr, 2011): It is reasonable that staff who do not feel able to serve current clients would be hesitant to encourage additional clients or begin broader community initiatives. However, as referenced by Ophelia’s comment “that people got to fight to keep them from closing down stuff”, one way to influence government decisions about community mental health care is to develop a strong base in the community who can advocate to policy makers on the agency’s behalf. Increased cooperation and engagement with community members will improve mental health care outcomes and possibly the future outlook of CMHAs.

**Future Research**

Further research is needed to test the hypotheses developed in this research that greater collaboration and information sharing between community mental health agencies and social support networks of rural African American men would increase the number of African
American male clients seeking care at community mental health agencies, would positively impact treatment outcomes for rural African American men, and would decrease mental illness stigma in rural communities. Subsequent research should examine the impact of social support participation in collaborative mental health care meetings on the three primary groups involved: clients, social supports, and staff. Analysis should be conducted regarding the relationship between social support involvement and client engagement with treatment such as missed appointments, client retention in care, medication compliance, and client satisfaction and outcomes. For social supports, relationships between satisfaction with care, knowledge about mental illness and treatment responses, and likelihood of referral to mental health care should be examined. Finally, data should be elicited from staff about their conceptualizations of client social support networks before and after social support participation in care and the benefits and ill effects of involvement.

This research was conducted solely in rural locations. Further research comparing rural and urban locations could provide insight into how the system interactions of clients, social supports, and agency staff differ in environments with higher population density and a greater array of social welfare resources. Additional research should also be conducted with African American men with serious mental illness who have left mental health care. Such data collection would help researchers to understand if there are distinct characteristics of social support networks that influence client choices to stay or leave care.
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APPENDIX A

AFRICAN AMERICAN MEN CLIENT INTERVIEW QUESTIONS

Brief Response Questions:*
*some questions modified from BASIS 24 (Eisen, Dill, & Grob, 1994) and the Family Communication Interview Guide, version 11 (Koehly, Peterson, Watts, Kempf, Vernon, & Gritz, 2003)

1. How old are you?

2. Are you now…
   - Married; Separated; Divorced; Widowed; Never married

3. How many children do you have?

4. Where did you sleep in the past 30 days?
   - Apartment or house; Halfway house/group home/board and care home/residential center/supervised housing; School or dormitory; Hospital or detox center; Nursing home/assisted living; Shelter/street; Jail/prison; Other

5. If you live with other people, how many and what is your relationship to them?

6. Do you have regular access to the internet? If so, where?

7. At any time in the past 30 days, did you work at a paying job?
   - No; Yes, 1 – 10 hours per week; Yes, 11 – 30 hours per week; Yes, more than 30 hours per week

8. At any time in the past 30 days, did you work at a volunteer job?
   - No; Yes, 1 – 10 hours per week; Yes, 11 – 30 hours per week; Yes, more than 30 hours per week

9. At any time in the past 30 days, were you a student in a high school, job training, or college degree program?
   - Yes or No

10. Do you now receive disability benefits; for example, SSI, SSDI, or other disability insurance?
    - No; Yes, I receive disability for medical reasons; Yes, I receive disability for psychiatric reasons

11. How do you pay for your mental health care?
    - out of pocket, private insurance, Medicaid/Medicare

12. What is your personal yearly income?
13. What is your total household income, including all earners in your household?

14. Do you rely on other resources besides monetary income (such as Medicaid, SNAP, food pantries, etc.)?

15. Do you pool or share resources with other people?

16. What, if any, is your religious preference?

17. If you identify with a religion, how active do you consider yourself in the practice of your religious preference?
   - Very active; Somewhat active; Not very active; Not active

Now, I want to get a sense of who you consider family. These can be people who are biologically related to you (like your children), people who are related to you but not through biological ties, (like your spouse/partner or in-laws), or people who you consider to be like family (like very close friends or coworkers). When I say “family,” who do you think of?

Now, for each of these persons, what is their relationship to you (e.g. friend, mother, cousin), their age, and their gender?

[List: first name, relationship, age, gender]

Open-Ended Questions:

Accessing and Utilizing Care

18. Are you currently receiving mental health services?
   If "Yes"
   a. Where?
      i. If in same agency...Why did you choose to continue there?
      ii. If different agency...Why did you choose to receive services at this facility rather than your previous provider?
   If “No”
   b. Why are you not currently accessing services?

19. When were you first diagnosed with a mental illness?
   a. What symptoms were you having that led to you being evaluated for a mental illness?

20. Please tell me about your mental health history. For example, tell me about where you’ve been treated and what types of care you received.

21. How did you hear about services at your local CMHA?
22. What made you decide to go to the CMHA for treatment?  
   a. Was there any reason you didn’t want to go?  
23. Were you worried about how you would pay for mental health care?  
24. Have you ever paid for care in ways other than how you now pay for care?  
   a. If you were not covered by Medicaid/Medicare and are now, did anyone from the  
      agency or your family help you to apply for coverage?  
25. Did any of the family members you listed above say anything to you about getting mental  
   health care? If so, who and what did he/she say?  

_Appropriateness of Care_  
26. When you think about the mental health care you received, please tell me what you  
   thought of the treatment. What was most helpful to you? What was least helpful?  
27. What do you think caused your mental illness? Do you think your mental illness can be  
   cured?  
28. What do you think your long-term prognosis is?  
29. Do you think there’s any difference between being a man and having a mental illness and  
   being a woman and having a mental illness?  
30. Do you think there’s any difference between being white and having a mental illness and  
   being black and having a mental illness?  
31. If someone asked you how your CMHA could get more African American men to come  
   to the CMHA for services, what would you suggest?  
32. If someone asked you how your CMHA could better serve African American men, what  
   would you suggest?  

_Social Support_  
33. How satisfied are you with your ________? How well do you think you fit in with your  
   ______?  
   Please rate each option on a scale of 1 to 4. (1 not at all happy/satisfied; 2 somewhat  
   happy/satisfied; 3 happy/satisfied; 4 very happy/satisfied)* modified from Linn, Husaini,  
   Whitten-Stovall, and Broomes, 1989)  
   a. Neighborhood  
   b. Church, if you attend church  
   c. Community
d. Therapeutic setting

34. I am now going to ask some questions about your family relationships. Again, please consider your list of family members as you answer the following questions. The answer to each question may be “no one,” a single family member, or several family members. Please let me know all of those that come to mind when you hear the questions. If another person who you think of as family comes to mind that is not on the list, please let me know and we will add them. Remember – we will not share your responses with anyone within your family.

35. Which members of your family help you? [e.g. provide a meal, labor, ride to the doctor.]

36. Which members of your family support you emotionally?

37. Who does not support you emotionally?

38. Who in your family do you get along with well?

39. Who in your family do you not get along with?

40. Who in your family do you spend the most time with?

41. Who in your family do you feel close with?

42. Is there anyone in your family you don’t feel particularly close to?

43. Whom can you count on to console you when you are very upset?

44. Whom can you really count on to be dependable when you need help?

45. Who would you not count on when you need help?

46. Whom can you really count on to listen to you when you need to talk?

47. To whom in your family do you listen?

48. Whose advice do you take?

49. Is there anyone in your family who you don’t listen to or ignore his or her advice?

50. Who in your family is involved in your care at the Community Mental Health Agency? Why/how are they involved?

51. Who knows your therapist/case manager or ever speak directly with them? What do they discuss?
52. Who knows what medications you take? Does he/she help you with your medication?

53. (If people are involved at CMHA), Do you think his/her involvement at the CMHA has affected your mental health care or treatment outcomes?

54. Are most of the people you have sex with in this group of people or outside this group of people?
   a. (If inside the social network) Can you tell me who you have sex with?
   b. (If outside the social network) Would you like to add anyone you have sex with to your social network list?

Thank you for taking the time to answer all my questions. Remember before the interview how we discussed if I could talk to some of your friends or family members about you and your mental health care? Now I’d like you to give me the names of three people you feel close to, who you rely on for support or advice, and who you are ok with me contacting.

1.

2.

3.

What is the best way to get in touch with each of them?
APPENDIX B
SOCIAL NETWORK CHART

Social Network Chart

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<table>
<thead>
<tr>
<th>Family</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(neighborhood, church support)</td>
</tr>
<tr>
<td>Work</td>
<td>Friends / acquaintances</td>
</tr>
</tbody>
</table>
```
APPENDIX C

SOCIAL SUPPORT NETWORK INTERVIEW QUESTIONS

Brief Response Questions*:
*some questions modified from BASIS 24 (Eisen, Dill, & Grob, 1994)

1. What is your gender?
   - Male or Female

2. Do you consider yourself Hispanic or Latino?
   - Yes or No

3. What is your racial background?
   - American Indian or Alaskan native; Asian; Black or African-American;
     White/Caucasian; Native Hawaiian or other Pacific Islander; Multiracial or other (please specify)

4. How old are you?

5. Are you now…
   - Married; Separated; Divorced; Widowed; Never married

6. How many children do you have?

7. In the past 30 days have you lived in a house, apartment, or mobile home that is
   - Owned by you or someone in this household with a mortgage or loan; Owned by you or someone in this household free and clear (without a mortgage or loan); Rented; Occupied without payment of cash rent?

8. If you live with other people, how many and what is your relationship to them?

9. Do you have regular access to the internet? If so, where?

10. How much school have you completed?
    - 8th grade or less; Some high school; High school graduate/GED; Some college; 4-year college graduate or higher

11. At any time in the past 30 days, did you work at a paying job?
    - No; Yes, 1 – 10 hours per week; Yes, 11 – 30 hours per week; Yes, more than 30 hours per week

12. If you did work, what type of work did you do?

13. At any time in the past 30 days, were you a student in a high school, job training, or college degree program?
- Yes or No

14. What is your personal yearly income?

15. What is your total household income, including all earners in your household?

16. Do you rely on other resources besides monetary income (such as Medicaid, SNAP, food pantries, etc.)?

17. Do you pool or share resources with other people?

18. What, if any, is your religious preference?

19. If you identify with a religion, how active do you consider yourself in the practice of your religious preference?
   - Very active; Somewhat active; Not very active; Not active

**Open-Ended Questions:**

**Accessing and Utilizing Care**

20. How long have you known x (x = client’s name)?

21. Please describe your relationship with x?

22. What do you think in general about mental illness and mental health care?

23. What do you think people in ____________ think about mental illness and mental health care?
   a. Your family (if X is a family member)
   b. The local African American community
   c. The community as a whole

24. What do you think about the local community mental health agency in particular? Has your opinion of them changed since x began receiving services there?

25. Did you know x when he first began to have symptoms of a mental illness?
   d. If so, please tell me about that time. What did you do about the situation at that time?
   e. If not, when did you become involved in x’s life?

26. Did you ever worry about how x would pay for mental health care?
**Appropriateness of Care**

27. Please tell me about your perception of x’s treatment.
   a. What do you think was most helpful to x?
   b. What was least helpful?

28. What do you think is the cause of his mental illness? Do you think x’s mental illness can be cured?

29. When x went to the CMHA, did he get what you expected there? Was it better, worse, the same as what you expected?

30. If someone asked you how your CMHA could get more African American men to come to the CMHA for services, what would you suggest?

31. If someone asked you how your CMHA could better serve African American men, what would you suggest?

32. Do you think there’s any difference between being white and having a mental illness and being black and having a mental illness?

33. Do you think there’s any difference between being a man and having a mental illness and being a woman and having a mental illness?

**Social Support**

34. X mentioned you as a source of support, what do you do to help x?

35. Why do you help x?

36. Have you ever gone to the Community Mental Health Center with x?
   a. Why or why not?

37. Do you know x’s therapist/ case manager or ever speak directly with them?
   f. Why did/do you go to see them personally?
   g. What did/do you discuss?

38. Do you know what medications x takes?
   h. Do you help him with his medication?

39. (If involved at CMHA), Do you think your involvement at the CMHA has affected x’s mental health care or treatment outcomes?
### APPENDIX D

### CLIENT PSEUDONYMS AND DEMOGRAPHICS

*Client pseudonyms: age, diagnosis, years in treatment*

<table>
<thead>
<tr>
<th>Client</th>
<th>Age</th>
<th>Diagnosis</th>
<th>Years in Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew</td>
<td>45 y/o</td>
<td>schizophrenia paranoid type</td>
<td>25 years</td>
</tr>
<tr>
<td>Brian</td>
<td>36 y/o</td>
<td>schizophrenia paranoid type</td>
<td>19 years</td>
</tr>
<tr>
<td>Caleb</td>
<td>41 y/o</td>
<td>schizophrenia paranoid type</td>
<td>8 years</td>
</tr>
<tr>
<td>Douglas</td>
<td>44 y/o</td>
<td>major depressive disorder</td>
<td>6 years</td>
</tr>
<tr>
<td>Elijah</td>
<td>46 y/o</td>
<td>schizoaffective disorder</td>
<td>9 years</td>
</tr>
<tr>
<td>Floyd</td>
<td>39 y/o</td>
<td>schizophrenia paranoid type</td>
<td>13 years</td>
</tr>
<tr>
<td>Gus</td>
<td>58 y/o</td>
<td>schizophrenia undifferentiated type</td>
<td>23 years</td>
</tr>
<tr>
<td>Hector</td>
<td>39 y/o</td>
<td>personality change due to general medical condition/ organic personality syndrome</td>
<td>8 years</td>
</tr>
<tr>
<td>Irving</td>
<td>32 y/o</td>
<td>mood disorder NOS</td>
<td>5 years</td>
</tr>
<tr>
<td>Joshua</td>
<td>41 y/o</td>
<td>schizoaffective disorder</td>
<td>4 years</td>
</tr>
<tr>
<td>Kordell</td>
<td>47 y/o</td>
<td>schizophrenia undifferentiated type</td>
<td>13 years</td>
</tr>
<tr>
<td>Lance</td>
<td>51 y/o</td>
<td>schizoaffective disorder</td>
<td>12 years</td>
</tr>
<tr>
<td>Malcolm</td>
<td>57 y/o</td>
<td>schizoaffective disorder</td>
<td>16 years</td>
</tr>
<tr>
<td>Norman</td>
<td>49 y/o</td>
<td>dual diagnosis mental illness substance abuse</td>
<td>9 years</td>
</tr>
<tr>
<td>Oliver</td>
<td>53 y/o</td>
<td>schizophrenia disorganized type</td>
<td>10 years</td>
</tr>
<tr>
<td>Peter</td>
<td>36 y/o</td>
<td>schizophrenia paranoid type</td>
<td>10 years</td>
</tr>
<tr>
<td>Quinton</td>
<td>48 y/o</td>
<td>schizophrenia paranoid type</td>
<td>16 years</td>
</tr>
<tr>
<td>Reginald</td>
<td>46 y/o</td>
<td>schizophrenia paranoid type</td>
<td>6 years</td>
</tr>
<tr>
<td>Sully</td>
<td>42 y/o</td>
<td>dual diagnosis mental illness substance abuse</td>
<td>14 years</td>
</tr>
<tr>
<td>Theo</td>
<td>53 y/o</td>
<td>depressive disorder NOS</td>
<td>4 years</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Diagnosis</td>
<td>Duration</td>
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<tr>
<td>---------</td>
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<td>----------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Ulysses</td>
<td>46 y/o</td>
<td>schizophrenia paranoid type</td>
<td>16 years</td>
</tr>
<tr>
<td>Vincent</td>
<td>52 y/o</td>
<td>schizophrenia paranoid type</td>
<td>11 years</td>
</tr>
<tr>
<td>Walter</td>
<td>53 y/o</td>
<td>schizoaffective disorder</td>
<td>31 years</td>
</tr>
<tr>
<td>Xavier</td>
<td>41 y/o</td>
<td>schizophrenia paranoid type</td>
<td>16 years</td>
</tr>
<tr>
<td>Yosiah</td>
<td>55 y/o</td>
<td>schizophrenia undifferentiated type</td>
<td>7 years</td>
</tr>
<tr>
<td>Zach</td>
<td>50 y/o</td>
<td>depressive disorder NOS</td>
<td>6 years</td>
</tr>
</tbody>
</table>

*Note: The client and social support names are randomly ordered and are not presented as pairs.*
### Social Support Pseudonyms and Demographics

<table>
<thead>
<tr>
<th>Social support pseudonym: gender, race, age, relationship to client</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ada: female, African American, 36 y/o, sister</td>
</tr>
<tr>
<td>Belinda: female, African American, 58 y/o, wife</td>
</tr>
<tr>
<td>Carol: female, African American and American Indian, 52 y/o, sister</td>
</tr>
<tr>
<td>Daphne: female, White, 52 y/o, girlfriend</td>
</tr>
<tr>
<td>Esther: female, African American, 68 y/o, mother</td>
</tr>
<tr>
<td>Franklin: male, White, 67 y/o, staff/friend</td>
</tr>
<tr>
<td>George: male, African American, 61 y/o, brother</td>
</tr>
<tr>
<td>Helen: female, African American, 52 y/o, fictive kin sister</td>
</tr>
<tr>
<td>Irene: female, White, 45 y/o, staff/coworker</td>
</tr>
<tr>
<td>Judith: female, African American, 86 y/o, mother</td>
</tr>
<tr>
<td>Karina: female, African American, 50 y/o, friend</td>
</tr>
<tr>
<td>Louis: male, African American, 54 y/o, brother</td>
</tr>
<tr>
<td>Milo: male, African American, 75 y/o, father</td>
</tr>
<tr>
<td>Nate: male, African American, 74 y/o, father</td>
</tr>
<tr>
<td>Ophelia: female, African American, 64 y/o, fictive kin mother</td>
</tr>
<tr>
<td>Preston: male, African American, 68 y/o, cousin</td>
</tr>
<tr>
<td>Quiara: female, African American, 53 y/o, mother</td>
</tr>
<tr>
<td>Ross: male, African American, 66 y/o, fictive kin brother</td>
</tr>
<tr>
<td>Sandy: female, African American, 54 y/o, mother</td>
</tr>
<tr>
<td>Tabitha: female, African American, 62 y/o, mother</td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Udell</td>
</tr>
<tr>
<td>Violet</td>
</tr>
<tr>
<td>Winifred</td>
</tr>
<tr>
<td>Xarah</td>
</tr>
<tr>
<td>Yvette</td>
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<tr>
<td>Zora</td>
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