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COMMUNICATING MENTAL ILLNESS IN THE BLACK AMERICAN COMMUNITY

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I do not recall what, exactly, happened when my father entered the room—if he spoke to me, or what the conversation between him and the guidance counselor entailed. However, there is one thing I remember clearly: what my father said in regard to what had required his presence there. When the guidance counselor expressed her concern about my suicidal thoughts, my father let out a hearty laugh and said, “If I gave her a gun, she wouldn’t even pull the trigger.” I cannot pinpoint why hearing those words upset me so much, but it did, and from that day on, I kept my mental issues hidden. Those words stuck with me throughout the years. My mother, too, did not take mental illness seriously. One day we got into a heated argument, and she mentioned I needed help. I recall requesting it, too, because even I knew that psychologically, something was wrong with me. When I questioned her about it later, however, she simply jokingly, stated, “There’s nothing wrong with you. You’re just crazy, and that cannot be helped. They can’t help you not be crazy.” My family did not deem my mental instability worthy of treatment, and consequently, I did not either. I tried to ignore my mental health issues altogether.

Later, however, I found that I was not alone. Many Black Americans deal with mental illness, though generally not at the same rate as White Americans, nor as long; typically, Black Americans experience mental illness during the young adult years, whereas White Americans experience mental illness during the years thereafter and have a higher rate of mental illness (Jackson et al., 2004; Woodward, Taylor, Abelson & Matsuko, 2013). These reports on prevalence and rate of mental illness in different ethnic groups are hard to decipher, however, because of “differences in the presentation of self-reported symptoms” (Woodward et al., 2013), which is likely to skew the results, especially for Black Americans. Within the Black American community, a “taboo nature of disclosure” influences their communication (Campbell & Mowbray, 2016, p. 261). For this reason, it could be said that mental illness is not taken seriously because of the taboo that surrounds revealing it. Disclosure of personal matters, such as mental illness, tend to be viewed negatively, which in turn can leave information about such matters scarce, or adverse. This paper presents findings from a qualitative interview study, which

builds upon previous studies' work, by exploring responses to mental illness among young Black Americans.

Literature Review: Mental Illness in the Black American Community

Mental illness is a topic that is often neglected and shunned in the Black American community. A review of the literature on mental illness yielded several potential reasons why communication about mental illness appears to be absent within the Black American community. The main contributors are stigma, lack of knowledge, mistrust, and preference for nonmedical coping mechanisms.

Stigma

The lack of discussion about mental illness in this community stems from stigma. In general, mental illness is stigmatized, as it is often associated with negative behaviors, such as unpredictability and danger (Alvidrez, Snowden, & Kaiser, 2008). Mentally ill individuals are often deemed dysfunctional and are seen as a danger to society. It could be said that this perceived view of the mentally ill is supported by fear. A copious amount of fear surrounds being considered mentally ill and being associated with the mentally ill, as it can have negative repercussions. Coincidentally, mentally ill individuals have internalized fear and dread of being labeled "crazy," which is an association repeatedly made throughout the dominant U.S. society and within the Black American community (Campbell & Mowbray, 2016). Although these stigmas hold true for anyone, they may be amplified for Black Americans.

In fact, Black Americans hold a higher degree of negativity toward mental illness than do members of any other ethnic group (Gaston, Earl, Niscani, & Glomb, 2016; Ward, Clark, & Heidrich, 2009) and are potentially already stigmatized because of what could be referred to as "double minority status" (Ward et al. 2009, p. 1589), in which their race and gender are utilized as catalysts for discrimination or maltreatment. Perry, Harp, and Oser (2013) found that the toxic mix of racism and sexism devalue the individuals and reinforce the stereotypes held about each group. Black males are seen as hardened criminals, and Black females as seductive, promiscuous beings. Being considered mentally ill within this community could hinder one's social status (Campbell & Mowbray, 2016), and thus Black Americans strive to avoid being defined as mentally ill, and discussing mental illness altogether.

Furthermore, this fear is intensified by the concern of appearing weak. There is a general belief that mental health is beneath Black Americans because they have overcome more challenging adversities, such as slavery (Alvidrez et al., 2008). This viewpoint follows the idea of “Black Power” or “Strong Black Woman,” which indicates that the strength of Black American individuals allows them to rise above any hardships, whether racism or mental illness. However, some Black Americans view mental illness as a normal part of life, not as an abnormality that needs to be corrected. Conner et al. (2010) found that Black Americans often considered symptoms, such as bouts of sadness, associated with mental illness as an everyday occurrence. When individuals seek treatment, they are therefore sometimes labeled as weak because they could not handle the normality of life (Gaston et al., 2016). In any case, the idea of weakness prevents Black Americans from seeking aid for their mental illness.

Lack of Adequate Knowledge and Resources

Sometimes mental illness is ignored because of the lack of adequate information about mental illness, its symptoms, and its treatment process (Ayalon & Alvidrez, 2007). This is plausible for the Black American community. In fact, many Black Americans go untreated because of their belief that treatment for mental illness is an option solely for Whites (Ayalon & Alvidrez, 2007). This reluctance to receive treatment may derive from Black Americans’ assumption that most medical professionals are insufficiently trained to diagnose them. This is not an unfounded assumption; although Black Americans and White Americans display symptoms differently, the majority of intervention practices are designed based largely on White Americans (Hunn & Craig, 2009). For example, Black American women often display their psychological symptoms physically, indicating that they have chest pain (Hunn & Craig, 2009). Thus, by receiving treatment that was created for White Americans, Black Americans run the risk of being misdiagnosed or of not being diagnosed at all. Additionally, according to Campbell & Mowbray (2016), attempts to educate the Black American community about mental illness did not reduce the stigma that Black Americans held about mental illness and, in some cases, even strengthened the stigma. This is not the sole reason that treatment is not sought, however.

When attempts are made to address mental illness in poor Black American communities, these attempts are often ineffective because of the lack of adequate resources for the whole community (Ward et al., 2009). The contrary is true for the White American community. Within the White American community, resources

for mental illness are plentiful and more readily available, as White Americans are more inclined to view mental illness for what it is—an illness (Campbell & Mowbray, 2016). Because the Black American community tends to stigmatize mental illness, however, resources are often not granted or even desired by the community. In addition to the aforementioned double-minority status and stigma, financial constraints seriously influence whether Black Americans get the help they need for their mental health. According to Gaston et al. (2016), many Black Americans do not seek treatment for their medical conditions, including mental illness, because of economic stressors, such as “lack of health insurance, unemployment, and poverty” (p. 686). If one struggles to pay one’s bills, seeking medical help for mental health may be the least of one’s worries, especially if there is a lack of satisfactory resources.

Mistrust

Another noteworthy reason why Black Americans do not discuss mental illness or seek professional aid is mistrust. This mistrust originates from the history of mistreatment that Black Americans have suffered from the hands of medical professionals (Hunn & Craig, 2009). For example, the Tuskegee experiment, which was conducted on Black American males who were ill-informed about the study, left everlasting effects on the community. The 40-year (1932–1972) study involved withholding treatment from 399 Black sharecroppers who had already been diagnosed with syphilis and observing how their bodies reacted to the illness (Poythress, Epstein, Stiles, & Edens, 2011). This experiment caused many unlawful deaths, as the researchers did not provide treatment to the participants, in order to view the end stages of syphilis. To this day, many Black Americans are still outraged about the experiment and many also state that they are afraid to participate in medical research or even to receive medical treatment, as they are wary of the medical professions’ intentions (Shavers, Lynch, & Burmeister, 2000).

Another reason for mistrust toward healthcare, especially for mental illness, is that many Black Americans believe that available treatments were designed for and by Whites (Alvidrez et al., 2008; Dennis, 2015). This belief is not without basis. As previously discussed, the majority of interventions for mental illness have been developed from research on White Americans and therefore could be inappropriate for Black Americans (Hunn & Craig, 2009). Each group has differing cultural backgrounds, experiences the world differently, and handles psychological issues differently. Because many of these differences are attributed to racial oppression and discrimination, treatments insensitive to racialized experiences cannot

appropriately address mental illness. Hunn and Craig (2009) found that Black Americans are often misdiagnosed with dysthymia instead of depression because “the source and context of their behaviors are misunderstood” (p. 88) due to their symptoms differing from already established symptoms. If not misdiagnosed, symptoms can also go undetected, leading to no diagnosis (Hunn & Craig, 2009).

Coping Mechanisms

It is possible that Black Americans tend to seek out forms of aid via different, nonmedical methods due to the mistrust they have toward health facilities. A common source for this aid is the church. According to Payne (2008), many Black Americans see religion as central to their lives and therefore turn to it as a source to combat their mental illness (Hunn & Craig, 2009); however, at the same time, many Black Americans see mental illness as incompatible with their religion (Ayalon & Alvidrez, 2007). Holpuch (2014) found that the reluctance to admit mental illness derives from the misconception of mental illness being caused by “demons, bad spirits or sin” (para. 6). Succumbing to mental illness could make the individuals appear anti-God, since the roots of mental illness are the enemies of God; therefore, instead of admitting their mental illness, individuals may try to control their “negative” emotions and embrace their love for the Lord through prayers (Payne, 2008). When prayers are not sufficient, individuals may turn to their ministers or to God for further aid. Black Americans rely on their ministers or the Lord to reconcile mental illness and religiosity, rather than seek traditional mental-health treatment (Ayalon & Alvidrez, 2007). Ministers serve as mediators who can aid individuals to feel comfortable with their mental illness or to reinforce that their belief in God is still strong.

Another common method of handling mental illness is to simply ignore it by focusing one’s energy on something else. Typically, this is done via the practice referred to as John Henryism, or Black Americans’ practice of utilizing hard work and determination to combat the mental and physical strain in one’s life (Hunn & Craig, 2009). This syndrome originated from an old tale from the 1800s about an exceptionally strong slave named John Henry who worked himself to death in order to prove himself (James, 1994). Many Black Americans disregard their mental illness by focusing their energy on their work instead of on their mental status, which in turn leads to no diagnosis or to misdiagnosis. Likewise, instead of focusing on work, some Black Americans may deal with their mental illness by engaging in “negative” activities such as isolating themselves from others and partaking in illegal activities, such as involvement with drugs (Gaston et al., 2016). These

activities allow them to shelter their mental illness from the community and to avoid further judgment.

In sum, mental illness within the Black American community is complex. Multiple differing ideas exist about how mental illness is viewed and managed within the Black American community, as well as about the effects this management has had on the community. Although insightful, much of the previous research has been conducted with older generations. Each generation faces different challenges and has different needs in response to changing sociocultural, political, and economic conditions. For example, the younger generation has become less religious because these individuals have been taught to “think for themselves—that they find their own moral compass” (Masci, 2016, para. 3). Young Black Americans also face new pressures that pose threats to their mental health, represented, for example, by police brutality against Black Americans and the conflicts over confederacy. There is a belief that the younger generation today is post-racial, but this is a misconception (Longmire-Avital & Robinson, 2017). Racism continues to affect Black youths’ mental health. Recent studies show that college students of color have a higher rate of unmet mental-health needs (Lipson, Kern, Eisenberg, & Breland-Noble, 2018; McGree & Stovall, 2015). According to Lipson et al. (2018), only 21% of Black American students received diagnosis, as compared to 48% for their White counterparts. In short, there is much to learn about young Black Americans’ experiences with and views of mental illness—the subject explored by this study.

This study also pays close attention to communication. Communication plays a vital role in constructing the social world, yet much of the literature on responses to mental illness within the Black community is psychologically oriented and focuses on individual concerns and characteristics. Pearce (2007) states how the communication that is utilized during commonplace conversations creates a social world that each individual resides in concurrently. Thus, what is uttered at one instance influences what happens next and creates a social world that the individuals will continuously interact in. Then, it is important to examine what kinds of communication are taking place to create and perpetuate this social world of mental illness. The current study therefore explores the following questions through qualitative interviews with young Black Americans.

RQ1: What ideas about mental health exist in the young Black American community, and how are they communicated?

RQ2: What are the potential factors that have influenced the communication practices utilized within the younger Black American generation?

RQ3: How does mental-health communication affect the treatment of mental health problems in the lives of young Black Americans?

Methods

This in-depth qualitative-interview study focused on the perception and communication of mental illness in the Black American community, with a particular focus on the younger generation. Rather than seeking generalization, this study sought detailed stories of six Black American young adults in college in order to understand the complexity and nuances in communicating and negotiating mental illness.

Participants

The participants were recruited at a local college in the Southeast United States through a snowball sampling method. This process involves informing possible participants of the study by spreading awareness of the study through various forms of communication, such as word of mouth and e-mail. To take part in the study, participants needed to be young Black Americans with firsthand experience with mental illness—for example, they themselves or a close friend or relative were mentally ill. All participants in this study fulfilled those requirements, and all mentally ill individuals were professionally diagnosed. The participants (four females and two males) were given pseudonyms to protect their identities (Wakanda, Queen J, Tom, Allison, Farrah, and Kerry). Their ages ranged from 20 to 25.

The interviews were conducted by the author in a private room in the university's library to provide security for participants. Each interviewee was asked a series of questions that arose from the research questions. Reflective questions were used in order to elicit responses about the individuals' firsthand experience with mental illness and to get an idea of participants' perception of and ideas about mental illness. Such questions included "How has the way mental health is communicated in the Black American community affected your perceptions?" and "Do you think young Black Americans view mental health/mental illness differently than the older generations?" Participants were also asked to explain the relationship between mental illness and religion. The length of the interviews ranged from 20 minutes to one hour. All of the interviews were audio-recorded with a tape recorder and later transcribed verbatim by the author. Each transcription was

typed in 12-point Times New Roman, which provided a total of 86 double-spaced pages.

Data Analysis

Each transcription was read by the author and the author's faculty advisor and was analyzed using thematic analysis, a "method for identifying, analyzing and reporting patterns (themes) within data" (Braun & Clark, 2006, p. 79). The process of thematic analysis involves six phases: familiarizing oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. Each of us read the transcriptions separately to familiarize ourselves with the data. Then, each generated codes within the texts that encompassed a general idea held via each participant. All codes were generated separately, and once we had created them, we came together to discuss them and why we deemed them important. Disagreements were discussed carefully and thoroughly until agreement was reached. Afterward, these codes were grouped together into overarching themes in accordance with the research questions. These preliminary themes were later condensed into more fitting themes and were renamed to accurately portray the findings.

Results

This section displays emergent themes in accordance with the three research questions. Where appropriate, the relevant literature reviewed earlier is incorporated. To a large extent, the interviewees' responses overlapped with the issues brought up in the literature. This is noteworthy because participants were not prompted to address these issues.

Existing Ideas about Mental Illness in the Black American Community

There are three primary themes with respect to the ideas that exist about mental illness in the Black American community: stigma, denial, and racial viewpoints. These themes build upon one another to create an overall negative idea about mental illness.

Mental Illness is Shameful and Fearful

Participants mentioned mental illness being viewed as something "bad to have" or a "handicap." Their perception followed the already established belief of

negativity and was often accompanied by shame or fear. Participants mentioned being “kind of hesitant to say there’s something wrong with me” or “I don’t want to have anything” when faced with the idea of potentially being mentally ill. For instance, when asked why Black Americans do not actively seek aid, Wakanda and Kerry stated that “Black people are just afraid to face it” and “people get a little bit scared.” Farrah said that she avoided treatment because of the “fear [that] trickled down to [her]” from her mother, as her mother was afraid of doctors. As previous research showed, mental illness is often ignored because of fear of being “shunned or avoided” as well as of being “stereotyped or misunderstood” (Waite & Killian, 2008, p. 183; Bains, 2014, p. 89). This fear of being stigmatized or ostracized for being mentally ill is a reality that continues to plague the Black American community and to deter acceptance of the illness.

Mental Illness does not Exist

According to the interviewees, the communication surrounding mental illness in the Black American community is poor or nonexistent. Mental illness “was not brought up enough” or “definitely not talked about a lot” in the Black American community. Participants had difficulty remembering instances when mental illness was discussed. One participant shared that her mental illness was never discussed within her family, although she was seeking therapy: “They put me in therapy or whatever, and even then, me and my momma *never* talked about it.” Her experience illustrates the passive denial of mental illness that occurs in the Black American community. Passive denial often occurs because of the belief that mental illness is a topic that is not to be discussed and should be avoided at all costs (Alvidrez et al., 2008).

When mental illness is not being ignored, it is often dismissed or actively denied. Several respondents recalled being told to “toughen up” or “get it together” when they disclosed their potential mental illness to others. Additional phrases they encountered repeatedly included “you’re crazy,” “you’re being dramatic,” and “you’re just being lazy.” These instances of active denial relied on attributing mental illness to anything else rather than acknowledging what it actually is—an illness. This is a common practice within the Black American community; as Waite and Killian (2008) state, mental illness is commonly believed to arise from a “weak mind, poor health, a troubled spirit, and lack of selflove” (p. 189). The participants’ experiences were consistent with this belief.

Mental Illness is a White Thing

As previously stated, there is a common belief within the Black American community that mental illness is strictly a White problem (Campbell & Mowbray, 2016). The interviewees echoed this belief. They remember being told, “Oh, stop acting White!” or “[Mental illness] is a White person problem.” This idea goes hand in hand with the stereotype of a strong Black man/woman (Ward et al., 2009). Wakanda stated that teachers would see the “disruptive” behavior of Black male students and simply think, *Niggas just acting out*. They associated his odd behavior with Black males acting tough. Another interviewee, Kerry, mentioned his own disbelief about his brother’s mental illness; he simply thought, *Eh, [he’s] Black. There’s probably nothing wrong with [him]*. In short, mental illness is often ignored due to the misconception that it is a White problem and cannot be experienced by Black Americans.

Factors Influencing Communication about Mental Illness

These ideas about mental illness in the Black American community arose from a number of contextual factors. In this study, three factors emerged: history, lack of knowledge, and attitude, which collectively shape a negative viewpoint of mental illness.

Historical Mistreatment of Blacks

Previous research showed the influence of the violent mistreatment that Black Americans have experienced throughout their history on the ways they perceive medical institutions in general (Hunn & Craig, 2009). The current study showed that the communication surrounding mental illness within the Black American community was influenced by this history. Wakanda, for example, mentioned that “we’ve been considered less-than all throughout history” and that this affects the communication surrounding mental illness because being mentally ill can work to confirm this perception. Unprompted, another participant, Allison, brought up the Tuskegee experiment (Ward et al., 2009) as being a main cause of the distasteful outlook and mistrust of medical institutions. The exploitation that Black Americans experienced in the past thus influences the communication that surrounds mental illness.

Lack of Knowledge

In addition to brutal history, the respondents believed that a general lack of knowledge about mental illness contributes to miscommunication and resulting mismanagement of mental illness. They stated that many Black Americans “don’t know about it,” “don’t know how to recognize it,” or “do not have anything” to check the misinformation that surrounds mental illness, thus confirming previous findings that many Black Americans “lack information about mental disorders and treatment” (Campbell & Mowbray, 2016, p. 253). Because of this lack of knowledge explaining mental illness, potentially mentally ill individuals are unaware of their own mental illness, as Farrah’s story illustrates. She was oblivious of its existence at first because of her lack of knowledge: “I’ve never been taught how to deal with it or notice it.” She was unable to properly identify it and consequently thought that she was just lazy or crazy; she fell victim to the idea that mental illness is shameful and should not be acknowledged.

Attitude

Another contributing factor that greatly influences the communication surrounding mental illness is the attitude that Black Americans hold toward mental illness. This attitude comprises a combination of pride, religion, and gender norms. According to the participants, Black Americans cannot “put their pride aside” to admit that they need help, or it is hard for Black Americans to seek treatment because pride gets in the way “when you come from a background where you’re not supposed to get help.” As previously shown, Black Americans place high value on “strength in the face of adversity” and thus take pride in not succumbing to mental illness (Alvidrez et al., p. 888). Pride dissuades individuals from admitting to being mentally ill; instead, they resort to heavy reliance on religion.

As the literature showed, God and religion play a vital role in day-to-day life of the Black American community (Payne, 2008). Multiple interviewees brought up the role of religion interfering with the communication surrounding mental illness. When mentioning their illness, they were told by others, “Pray and it’ll go away,” “God will help you,” or “You just need to go to church.” Mental illness is viewed as an obstacle that religiosity can combat; therefore, some participants were told, “You must not be praying hard enough,” when their mental illness persisted. In the experiences of the interviewees, this faith in religion for curing mental illness greatly affects the communication surrounding mental illness and, as will be discussed later, the treatment for mental illness.

Another common discourse about mental illness is gender norms. If a male were to disclose that he is potentially mentally ill, he would not be met with supportive talk. Instead, he would be patronized. One interviewee, Tom, stated,

From a male perspective, it's like you're supposed to be the strong . . . strong Black male. You're supposed to be . . . you ain't supposed to cry. You ain't supposed to deal with nothing. You ain't supposed to show no emotions. You're supposed to be—BOOM. BOOM. Solid.

Masculinity plays a critical role in how mental illness is treated, and mental illness is often ignored so as to avoid being labeled weak or unmanly (Bains, 2014). This idea of not wanting to be perceived as weak or unmanly circles back to the stigmatized idea about mental illness, on the one hand, and the expectation to follow the stereotypical idea of masculine "Black Power," on the other.

An additional factor that influences the attitude about mental illness is generational differences. Previous literature did not explore how this factor may influence the communication surrounding mental illness. It was, however, brought up repeatedly by the participants in this study; younger generations tend to have differing viewpoints on mental illness, and thus, their communication surrounding it differs from that of older generations. This study's interviewees considered themselves as part of the younger generation and as being "open-minded" to the idea of mental illness's existence. More importantly, they were more inclined or "willing" to try treatment practices created for mental illness. They credited this to the availability of resources, such as the Internet, Google, and Instagram memes. These resources allowed the interviewees to be more accepting of mental illness.

Additionally, interviewees felt that the communication about mental illness must change. As discussed next, they often viewed as problematic or ineffective the conventional strategies used by their community to address mental illness.

Conventional Responses to Mental Illness in the Black American Community

Marginalization by Others and by Self

The participants agreed that mental illness is marginalized in the Black American community. This marginalization is believed to occur because of the "cultural perceptions that Black Americans are 'strong,'" thus indicating that mental-health services are not needed (Gaston et al., 2016, p. 686). Multiple

participants shared this belief, stating that Black Americans “act like it doesn’t exist” or “don’t deal with it.” Instead of admitting that mental illness exists and participating in active, healthy manners of combating it, Black Americans ignore it and/or do not take it seriously because they believe they are strong enough to prevail over the illness. Queen J mentioned how Black Americans tend to be self-centered, as they “don’t check on others” to see how others are doing mentally. This refusal to check on others could stem from the idea that Black Americans have more shameful attitudes toward friends who struggle with mental illness (Ward et al., 2009). Consequently, it is possible that many are dealing with mental illness without disclosing to each other and trying to handle it on their own.

Given the stigma attached to mental illness in the Black American community, it comes as no surprise that the mentally ill are often left to tend to their mental health alone. The mentally ill become reliant on their inner selves to deal with their mental illness (Bains, 2014). All of the interviewees mentioned differing methods to cope with their mental illness, with a majority of the methods being negative. Such coping mechanisms included “bottling things up,” going through “hoop phases,” “cutting,” and “not eating,” to name a few. These practices were utilized to weaken the pain that they felt from their mental illness. Unfortunately, these methods did little to ease the internal pain. As one participant, Allison, stated,

I’m still depressed because . . . acting out sexually was a way to feel something. Because, like, I really didn’t know how to identify my emotions well back then. And so, I took . . . loneliness and connected that to sex, because you get someone to come over so they’re technically with you . . . but then they leave, and so, I was just stuck with all of those feelings.

These self-marginalization methods had little promise of making the mentally ill feel better. In fact, they only enhanced the solitude or pain that the mentally ill were feeling, which could lead to more-drastring measures, as in the case of Wakanda’s aunt, who acted “strangely” before attempting to commit suicide:

She was quiet. She wasn’t talking to anybody. She wasn’t eating; like I said, she dropped a bunch of weight. And, so . . . what finally got us to, like, commit her was when one night, she had woke my cousin up, which is her son. Like, she was rumbling through the drawers and when he woke up and came in there, she had a knife. Like she was about to kill herself, so, that’s when they committed her.

Self-marginalized practices can build up over time to more dire situations, such as suicide. For this reason, when the first few instances of self-marginalization are noticed, traditional methods of aid are sought.

Seeking Professional Help

A few participants mentioned utilizing traditional methods to deal with their mental illness, including using medication, seeking therapy, and being institutionalized. Farrah, for example, sought treatment because “I’m tired of feeling empty. I’m tired of, like, being on a rollercoaster. Or like, breaking down, or just, this isn’t normal. This wasn’t me.” Farrah’s desire to enter treatment derived from an inner place of wanting to become better, which is a common occurrence for mentally ill individuals. As stated by Ayalon & Alvidrez (2007), the main reason why the mentally ill seek treatment originates from their acknowledgment of “high levels of need, symptoms becoming too bothersome, or suicidality” (p. 1330). The mentally ill become exasperated with feeling the way they do and thus seek treatment. Other interviewees shared this idea as well; they mentioned seeking aid because of “being suicidal” or “not feeling normal.”

For the majority of participants, seeking aid meant becoming medicated. They used medication to combat bipolar disorder, anxiety, or depression. Interestingly, however, the participants terminated their medication early because “I don’t feel like I could live being on that forever” or “I did not like the effects.” This is consistent with previous research: Black Americans typically do not complete and/or adhere to their recommended treatment (Ayalon & Alvidrez, 2007). This unwillingness to adhere to their treatment or to become dependent on the medication also possibly relates back to the idea of “strong Black men/women” who are able to overcome any adversity.

Different from the older generations’ tendency to avoid therapy, the young Black interviewees stated that they used therapy to help them manage their mental illness. Farrah, for example, liked therapy because “you have somebody to talk to who doesn’t judge you.” A few interviewees mentioned how they needed someone to talk to about their mental illness and, because mental illness is viewed so badly in the Black American community, they turned toward therapy. Whereas previous research pointed out ethnic mismatching or “lack of culturally competent services” as prevalent reasons why Black Americans do not complete and/or seek therapy (Ayalon & Alvidrez, 2007, p. 1324), participants in this study welcomed therapy. Some even held different views on ethnic matching for therapy. For example, Wakanda felt that connection had little to do with racial similarities:

Although I feel like . . . we had two different walks of life, I still felt like I could relate with her more than I would with somebody else. . . . When you feel like you could relate to someone more, or somebody would have a better understanding of what you're going through, it's easier for you to open up.

Allison, on the other hand, felt that race matters, but sharing race (thus the racial culture) also presented a challenge:

I feel I can connect with [Black therapists] because . . . they won't try to go—step into that traditional path. But, also, I feel kind of weird. So, like with the third one that was an African lady woman, I felt more timid in speaking about how I feel about my mom. Because, you're supposed to be tight-knit in the family. I could care less, unfortunately, about my family.

Different from the previous literature, then, the lack of cultural matching seemed to present little problem or was even desired in this study's participants. Allison was hesitant about having a Black therapist because of the norm in the Black American community as to what should and should not be disclosed about the family. Interestingly enough, another participant, Farrah, mentioned preferring White therapists because they are "more creative." At least for these young participants, cultural matching was not important or desired in terms of therapy.

Religion as the Answer

As the literature showed, there is a strong reliance on religion in the Black American community in handling mental illness. Religion affects both the communication that surrounds mental health and the treatment that is sought. Many respondents mentioned being referred to religion and/or God to treat their mental illness—to pray more, to attend church more frequently. Allison's story is illustrative of this:

But after talking to me, he was like, "Alright. Let's go down to the church and we're gonna talk to a pastor." And I was like, "He's not really mine. I don't want to go to church on Sunday with y'all." Um, but, yeah. We went to the church and then his pastor was like, "Alright. Here's this therapist I know." And I was like, "Is—is she with the God too? Thank you for helping, but like, no! I'm not really feeling that connection with Jesus yet." . . . But it always seems like the first immediate response is "Alright. We're going to church." If

it's not that, it's just—"You're just fucked up! I can't help you if, you know, you don't go to church."

Allison's experience is a typical one. Black Americans often seek nonmedical methods such as speaking to ministers to treat mental illness, and attribute religion to healing mental illness more than traditional methods (Payne, 2008).

Preferred Ways to Address Mental Illness in the Black American Community

As shown above, participants in this study experienced typical responses to mental illness, and they all felt that these responses by the Black American community were not ideal. They felt that more constructive approaches were needed.

Improved Social Environment

Currently, mental illness is overwhelmingly stigmatized in the Black American community, thus creating an overall negative environment. Several interviewees suggested alleviating the stigma that surrounds mental illness by talking about mental illness more or by simply "building support groups." These support groups, which could include family, friends, counselors, and so on, would be able to create a welcoming environment around mental illness. It has been found that an environment that supports mental illness as well as the mentally ill creates a more positive image about mental illness (Ayalon & Alvidrez, 2007). The participants in this study made a number of suggestions, including "not portraying [mental illness] as if something's bad but portrayed as we are all as one" and "not separating people who do have mental illness from those who don't." Specifically, Allison mentioned "bring[ing] people in to talk about mental illness" because having a personal account of mental illness from a mentally ill individual opened her eyes. Kerry similarly stated,

I almost had the same ignorant mindset like, "Eh, you're Black. There's probably nothing wrong with you." But that was a nice little wake-up call. It helped me realize, "Oh, snap! I do need to actually be careful about this. I need to be sensitive." You never know what somebody is going through.

Being around a mentally ill individual thus changed Kerry's perspective.

The participants all pointed out the importance of creating a social environment that allows dialogues with people with mental illness as the first step toward changing the ways mental illness is viewed in the Black American community.

Build Knowledge

As previously stated, a lack of knowledge contributes to negative communication surrounding mental illness. Lack of knowledge about mental illness tends to influence the views that some individuals hold about it and its treatment (Gaston et al., 2016); however, this can change if, as suggested by the interviewees, the community promotes mental-illness awareness and individuals educate themselves. Here, universities play important roles, as they can promote mental-illness awareness to young adults (Longmire-Avital & Robinson, 2017). In fact, some universities began to promote awareness of mental illness by having a mental health month. One interviewee brought up this idea of “mental health awareness month” as something the Black American community should adopt as well. Another interviewee, Wakanda, stated that her knowledge on mental illness began to grow once she entered college and took psychology classes, as well as that she gained insight via TED talks. Queen J said that she promotes mental illness awareness with others: “I try to give them the information that I’ve gotten so they understand that there’s different types of mental illnesses and you just learn how to cope with different things.” Each of these attempts to build knowledge helps to lessen the stigma that surrounds mental illness and hopefully begins to change the attitudes held about it.

Attitude

There is a general unwillingness in the Black American community to disclose mental illness because of the attitudes held about it (Hunn & Craig, 2009). The respondents felt that, in order for mental illness to be seen in a positive light, there needed to be an attitude adjustment: becoming open-minded, taking mental illness seriously, and not being so reliant on religion. The interviewees mentioned making the communication surrounding mental illness more open. Farrah stated, “Don’t talk at them; talk *with* them.” Often, individuals’ attempts at communicating their mental illness are shut down by being told nothing is wrong and they just need to “buck up,” which in turn often leads to self-marginalizing practices, such as not disclosing their mental state. The communication surrounding mental illness must be more inclusive and dialogic.

Multiple interviewees also suggested that heavy reliance on religion to deter mental illness must be reevaluated. The strong dependence on religion (Payne, 2008) often stops mental illness from being addressed properly. The participants supported this idea. Farrah stated, "I believe in God too. I'm a die-hard believer, but if you need help, you need help," to reinforce the idea of not relying solely on God. This concept was further explored in Tom's response: "I firmly believe that God will make a way, but I also feel like, sometimes he puts these steps . . . or things in front of you to help you." Another participant, Kerry, combined the two aforementioned ideas. He mentioned that "God wants us to pray, but God also wants us to take action. So, we combined the two forces, I guess you should say" in regard to utilizing other methods alongside religion for treating mental health. Each interviewee recognized that religion and God can help to lessen the challenges of mental illness to some degree but that other actions need to be taken in order to best address the problem.

Discussion and Implications

Notably, a copious amount of the findings from this study supported the findings from the prior research on mental illness in the Black American community. It appears that stigma is the leading cause of how mental illness and the mentally ill are treated. As previous research showed, mental illness tends to be looked at negatively in general, but that negative view is typically amplified in the Black American community because of the additionally stigmatizing status that mental illness brings to members of the community (Campbell & Mowbray, 2016). This is supported by the aforementioned double-minority status as well by as gender norms, reluctance to disclose, and history, as reinforced by the participants' responses. The stigmatizing nature surrounding mental illness tends to create an inimical perception that creates shame, fear, and denial and often influences others to take on this negative stance. With these ideas in practice, awareness of mental illness becomes stunted, resulting in a lack of knowledge of and a disavowing attitude toward mental illness. This creates an everlasting cycle that produces negative communication that affects not only the mentally ill but everyone.

Negative communication about mental illness disadvantages the entire community, not just the mentally ill, as maintained by the interviewees' insights. None of them had anything positive to share about the relationship between mental illness and the Black American community, as the communication within this community tends to disparage mental illness. As found by Campbell & Mowbray (2016), the "racializing and gendering" of mental illness greatly influences how one

interprets and understands the notion (p. 260). Kerry's insistence that his brother could not be mentally ill because of his race and gender ties into this idea as well as the notion of "Black Power" and "strong Black woman/man." These ideas have a tendency to obstruct the relationship between the mentally ill and non-mentally ill, thus creating a hostile environment and further division between the two groups. Furthermore, because the marginalization of mental illness is not about diagnosis but rather about the communication around it, marginalization affects anyone who may display the symptoms—whether diagnosed or not—by silencing their experiences or preventing them from seeking needed help. Thus, changing the communication surrounding mental illness is a key to a better understanding of and response to it.

Communication is a powerful tool that holds great influence and power. This is why it is important to look at mental illness from a communication perspective as this study did. This study built upon prior research by showing how what we think and believe—an integral part of psychology—is shaped by communication. As Pearce (2007) argued, each communication has an "afterlife" (p. 2) in that it has a consequence; it helps to shape a social world. The communication about mental illness in the Black American community has been overwhelmingly negative. Every statement made about mental illness has an effect in the lives of each individual—mentally ill or not and diagnosed or not—and consequently influences communication about mental illness in the future with others, hence creating a cycle of negativity about mental illness—a cycle that is often hard, but not impossible, to break.

Pearce (2007) mentioned how "every turn in a conversation is a bifurcation point," meaning that the communication surrounding any given subject could be changed, leading to a different afterlife and thus to a social world (p. 5). The younger generation is already beginning this process by using bifurcation points to change the perceptions held about mental illness and provide a hospitable outlook. Participants in this study mentioned utilizing the Internet to create an open dialogue about mental illness, as well as becoming more comfortable with being mentally ill. Others stated how the college environment aided in this process, as universities typically have a mental-health-awareness month. College is a privileged space that not everyone has access to, however.

The idea of bifurcation points, the generational changes, and college as a privileged space together lead to an important practical implication. Is it possible for these bifurcation points to happen outside of college—perhaps in the church or other community spaces? As mentioned earlier, religion is seen as a central element

in the lives of many Black Americans (Payne, 2008); additionally, the church is seen as a “primary source of spirituality, social support, and connectedness” (Hunn & Craig, 2009, p. 87). Conceivably, this location could be utilized to create a space for open dialogue about mental illness for all members of the congregation to partake in. Perhaps these dialogues can begin to alleviate the stigma surrounding mental illness and create compassion for it—a bifurcation point that can change the perception of mental illness and create a new afterlife surrounding it.

Finally, this study’s findings point to several implications for future studies. First, conducting similar research with more participants of both sexes and other demographics (class, sexuality, region, etc.) will help to see if the findings from the current study are shared by larger and diverse groups of young Black Americans. My participants mentioned that the reason their perceptions of mental illness differed from the older generations’ is because of education. In previous research, however, increased learning about mental illness did not help to ease negative views of it. Future research needs to explore this inconsistency and what kinds of educational programs about mental illness are helpful in the Black American community. Another area to be explored is the role played by therapists. In my study, the race of the therapist was important for some and not for others. Some questions that could be explored include “Do Black American therapists make treatment easier and more comfortable to partake in for Black Americans?” and “What communication is likely to be helpful if the therapist is non-Black?” An additional area of research may be the influence of historical racial injustices experienced and endured by the Black American community on how Black Americans treat mentally ill individuals within their community. Finally, the role of religion must be explored more. Given the importance of religion in this community, how can religious leaders, families, and medical professionals work together to better approach mental illness? All these areas should be studied through means of research such as qualitative interviews that allow in-depth understanding of communication about mental illness in the Black American community.

Conclusion

This study explored young Black Americans’ experiences with and views of mental illness within the Black American community from a communication perspective. In particular, the study examined the ideas about mental illness communicated to young Black Americans, and how those young Black Americans felt about and responded to the ideas. Although the findings are limited to the six participants and can certainly benefit from further study, the fact that the

participants' experiences and observations overlapped with the previous findings and themes suggests that the patterns of negative perceptions and discourse about mental illness persist in the Black American community. The perceptions and discourse cyclically influence each other.

I began this paper with a personal story because this topic is as much personal as it is social. Conducting a review of literature and interviewing my fellow young Black Americans affirmed that we as a community must shift conversations about mental illness. This begins within one's own family. Earlier in the year, I was able to present this research at a local conference. I invited my father to come to listen—a bifurcation point in our conversation. He sat in on my presentation and told me afterward how insightful it was and how his perspective on mental illness began to change as he listened to me talk. A new social world is forming in my family, and I hope to do the same with others. My sister said it best after reading this paper: "Open up that dialogue. It needs to be heard so others can understand."

References

- Alvidrez, J., Snowden, L. R., & Kaiser, D. M. (2008). The experience of stigma among Black mental health consumers. *Journal of Health Care for the Poor and Underserved, 19*(3), 874–893.
- Ayalon, L., & Alvidrez, J. (2007). The experience of Black consumers in the mental health system. *Issues in Mental Health Nursing, 28*(12), 1323–1340.
- Bains, R. M. (2014). African American adolescents and mental health care: A metasynthesis. *Journal of Child and Adolescent Psychiatric Nursing, 27*(2), 83–92.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.
- Campbell, R. D., & Mowbray, O. (2016). The stigma of depression: Black American experiences. *Journal of Ethnic & Cultural Diversity in Social Work, 25*(4), 253–269.
- Conner, K. O., Copeland, V. C., Grote, N. K., Rosen, D., Albert, S., McMurray, M. L., . . . Koeske, G. (2010). Barriers to treatment and culturally endorsed coping strategies among depressed African-American older adults. *Aging & Mental Health, 14*(8), 971–983.
- Dennis, K. N. (2015). Debunking myths about mental illness among blacks. *Scholars Strategy Network*. Retrieved from <https://scholars.org/brief/debunking-myths-about-mental-illness-among-blacks>
- Gaston, G. B., Earl, T. R., Nisanci, A., & Glomb, B. (2016). Perception of mental health services among Black Americans. *Social Work in Mental Health, 14*(6), 676–695.
- Holpuch, A. (2014). Christians and mental health: ‘This has nothing to do with whether I believe in Jesus’. *The Guardian*. Retrieved from <https://www.theguardian.com/world/2014/nov/13/evangelicals-increasingly-putting-faith-in-medicine-to-treat-mental-health-issues>

- Hunn, V. L., & Craig, C. D. (2009). Depression, sociocultural factors, and African American women. *Journal of Multicultural Counseling and Development, 37*(2), 83–93.
- Jackson, J. S., Torres, M., Caldwell, C. H., Neighbors, H. W., Nesse, R., Taylor, R. J., . . . Williams, D. R. (2004). The National Survey of American Life: A study of racial, ethnic and cultural influences on mental disorders and mental health. *International Journal of Methods in Psychiatric Research, 13*(4), 196–207. <https://doi.org/10.1002/mpr.177>
- James, S. A. (1994). John Henryism and the health of African-Americans. *Culture, Medicine and Psychiatry, 18*(2), 163–182.
- Lipson, S. K., Kern, A., Eisenberg, D., & Breland-Noble, A. M. (2018). Mental health disparities among college students of color. *Journal of Adolescent Health, 63*(3), 348–356. doi:10.1016/j.jadohealth.2018.04.014
- Longmire-Avital, B., & Robinson, R. (2017). Young, depressed, and Black: A comparative exploration of depressive symptomatology among Black and White collegiate women. *Journal of College Student Psychotherapy, 32*(1), 53–72.
- Masci, D. (2016). Q&A: Why Millennials are less religious than older Americans. Retrieved from <http://www.pewresearch.org/fact-tank/2016/01/08/qa-why-millennials-are-less-religious-than-older-americans/>
- McGree, E. O., & Stovall, D. (2015). Reimagining Critical Race Theory in education: Mental health, healing, and the pathway to liberatory praxis. *Education Theory, 65*(5), 491–511. doi:10.1111/edth.12129
- Payne, J. (2008). “Saints don't cry”: Exploring messages surrounding depression and mental health treatment as expressed by African-American Pentecostal preachers. *Journal of African American Studies, 12*(3), 215–228.
- Pearce, W. B. (2007). *Making social worlds: A communication perspective*. Malden, MA: Blackwell.
- Perry, B. L., Harp, K. L. H., & Oser, C. B. (2013). Racial and gender discrimination in the stress process: Implications for African American women's health and well-being. *Sociological Perspectives, 56*(1), 25–48.

- Poythress, N., Epstein, M., Stiles, P., & Edens, J. F. (2011). Awareness of the Tuskegee syphilis study: Impact on offenders' decisions to decline research participation. *Behavioral Sciences & the Law*, *29*(6), 821–828.
- Shavers, V. L., Lynch, C. F., & Burmeister, L. F. (2000). Knowledge of the Tuskegee study and its impact on the willingness to participate in medical research studies. *Journal of the National Medical Association*, *92*(12), 563–572.
- Waite, R., & Killian, P. (2008). Health beliefs about depression among African American women. *Perspectives in Psychiatric Care*, *44*(3), 185–195.
- Ward, E. C., Clark, L. O., & Heidrich, S. (2009). African American women's beliefs, coping behaviors, and barriers to seeking mental health services. *Qualitative Health Research*, *19*(11), 1589–1601.
- Woodward, A. T., Taylor, R. J., Abelson, J. M., & Matusko, N. (2013). Major depressive disorder among older African Americans, Caribbean Blacks, and Non-Hispanic Whites: Secondary analysis of the national survey of American life. *Depression and Anxiety*, *30*(6), 589–597.
doi:10.1002/da.22041