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Mental Health Symptoms and Service Use Patterns of African American Women

Vickie M. Mays
Cleopatra Howard Caldwell
James S. Jackson

There has been increasing concern among mental health service professionals about the problems faced by ethnic minorities, particularly African Americans,[1] and their underuse of traditional mental health services (Comas-Diaz, 1992; Mays, 1995; Mays & Albee, 1992; Neighbors, 1985; Solomon, 1988; Sue, McKinney, Allen, & Hall, 1974; Yamamoto, Dixon, & Bloombaum, 1972). Many of the studies reported in the literature focus on the problems of the use of psychotherapy and mental health services within the context of patient-therapist social class levels, interracial treatment dyads, approach to treatment (i.e., psychotherapy versus medication) (Flaherty, Naidu, Lawton, & Pathak, 1981; Sue, 1977; Yamamoto, James, & Palley, 1968), misdiagnosis of minority patients (Lawson, Hepler, Holladay, & Cuffel, 1994; Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983; Strakowski et al., 1995; Strakowski, Shelton, & Kolbrener, 1993) and other structural factors in the provision of

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mental health services to minority populations (Mays, 1985). Few studies are available that inform service providers of the factors influencing the help-seeking and mental health service use process from the perspective of the intended client. Seldom have research questions focused on the types of problems that ethnic minorities regard as appropriate for seeking professional services or on the factors that influence their decision to seek professional mental health services. This seems particularly important because studies indicate that some black Americans are less likely to use outpatient mental health services and more likely to (a) use informal sources of help for their problems (Neighbors, 1985; Vernon & Roberts, 1982), (b) leave treatment prematurely (Acosta, 1980; Sue, 1977; Yamamoto et al., 1968) or (c) benefit less than do whites, Mexican Americans, or Asian Americans from treatment (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Such findings have raised questions for concerned mental health professionals about the adequacy, cultural appropriateness, and responsiveness of current mental health services to the unique ethnic-cultural values and life experiences of black Americans (Mays, 1995; Mays & Comas-Diaz, 1988).

Such questions seem appropriate as we enter an age of managed mental health services in which interest centers on early identification of problems in order to prevent episodes of serious mental illness. In the African American community, where healthy distrust and wariness about psychotherapy continues in the face of studies that document the higher incidence of psychiatric misdiagnosis (Lawson et al., 1994; Mukherjee et al., 1983; Strakowski et al., 1995; Strakowski et al., 1993), substandard assignment in referral practices for treatment and reliance on medication (Lawson et al., 1994; Lewis & Shanok, 1980; Strakowski et al., 1995), and a long, checkered history of racial mistrust between black and white Americans (Lawson, 1986; Mays & Cochran, 1994, 1996; Neal & Turner, 1991; Worthington, 1992), those African Americans who cross the thresholds of public or private mental health centers have made strong statements regarding their problems and their ability to cope (Block, 1981).

These individuals have acknowledged that their problems are within and have demonstrated a willingness to risk treatment in a historically negative environment (Block, 1981; Worthington, 1992). By seeking help from traditional professional mental health services, they are indicating to some extent that the support mechanisms that blacks usually rely on for help with personal problems (Neighbors, 1985, 1988), such as ministers, general physicians, medical emergency rooms, and friends, may not be working. The decision to seek mental health services is often not consistent with African American

cultural coping styles that emphasize use of informal systems and the ability to "do it" oneself (Block, 1981; Mays & Comas-Diaz, 1988). Block suggests that help seeking for environmental needs within the family and through social service agencies is culturally permissible in the black community. On the other hand, admitting an intrapsychic problem that cannot be solved by oneself or with informal help is often not consistent with images of how ethnically identified blacks cope with problems. This is particularly true for black women, for whom the tradition of being self-reliant is synonymous with the role of being an adult black woman (Mays, 1995; Mays & Comas-Diaz, 1988; Robinson, 1983).

Service Use Research

Research on the mental health service use patterns of black Americans is a mixed picture, with some studies reporting underuse (Smith, 1981; Sue, 1977) and others reporting overuse (Bui & Takeuchi, 1992; Dawkins, Dawkins, & Terry, 1979; Flaskerud & Hu, 1992; Smith, 1981; Sue et al., 1991). Cheung and Snowden (1990), in their review of mental health service use patterns, cite several studies reporting an increase in use by African Americans, especially in inpatient and residential care. Critical to the picture is whether the data are based purely on public health facility use or whether patterns of service use with private mental health practitioners and facilities are included. Data on the latter are often harder to collect in that diagnosis or use may never be recorded because of the lack of any third-party intervention requiring a record or the lack of accurate reporting of the true nature of the psychological problems because they become a part of a permanent health record when third-party payments are involved.

The picture of use among African American women is no clearer. Some research studies have demonstrated an underuse of psychotherapy services by black women (Armstrong, Ishiki, Heiman, Mundt, & Womack, 1984; Smith, 1981; Sue, 1977; Sussman, Robins, & Earls, 1987) with patterns different from those of white women or black men. Earlier studies based on national statistics revealed that black women have a higher use rate of public rather than private mental health facilities, whereas the opposite is true of white females (Smith, 1981). Although Blacks as a group use community mental health centers at almost twice the rate of the general population (Rudov & Santangelo, 1978), black women use these facilities less than do black men.

This is opposite the pattern for white women and men (Smith, 1981). This tendency of black women to use community mental health services less when compared to other groups was supported in a study that analyzed the use patterns of ethnic minorities in 17 community mental health centers. Contradictory evidence, however, was found in a study of users of public mental health facilities in Chicago where black women used services at almost twice the rate of African American men (Dawkins et al., 1979). Interestingly, in a study of the client population of a group of black psychiatrists, more black women than men were seen, and for both black women and men they were more likely to be seen as private clients rather than as patients of mental health facilities (Jones & Gray, 1984).

Other sociodemographic patterns of African American women's use of psychotherapy services indicate that they use public services and private facilities most often during the 25 to 44 age range (Jones & Gray, 1984; Smith, 1981). Users of both public and private mental health services among women tend more often to be married (Dawkins et al., 1979; Jones & Gray, 1984). The status of the next largest group of private practice users is divorced women, which contrasts with the second-largest group of private practice users of black men, who are more likely to be single.

Data on education and employment status were found only for users of private therapists (Jones & Gray, 1984). Black women, like black male users of services, were typically in technical or semitechnical professional occupations, with black women professionals being the second-largest group. The educational level of black women was a little higher than that of black men, with more high school or college graduates among the women. The patterns of black women's use of mental health services are more different from than similar to those of either white women or black men. In addition, when users of public versus private mental health services are compared, differences are noted among black women. Other studies support the influence of education on mental health service use rates. Capers (1991) and Flaskerud (1980) found that black Americans with higher levels of education sought psychiatric management of their problems more frequently than did those with lower levels of education.

Yet using only sociodemographic variables as criteria for the evaluation of mental health services to African American communities has been found to be inadequate (Block, 1981; Dawkins et al., 1979). Not enough attention has been given to the role of culture or lifestyle characteristics as means for identifying mental health needs and for planning mental health services for

black Americans (Dawkins et al., 1979). Attitudes and beliefs regarding what constitutes a psychological problem and when and who one seeks help from are often mediated by gender, culture, and racial-ethnic factors (Cleary & Mechanic, 1983; Hough et al., 1987; Marsella, Kinzie, & Gordon, 1973; Mays & Comas-Diaz, 1988). Black Americans sometimes seek help for psychological problems from informal sources—friends, relatives, church members (Neighbors & Jackson, 1984; Taylor, 1986c; Taylor & Chatters, 1988). As an example, some blacks cope with distressing problems by turning to religion, prayer, or church members for support in handling that problem. A study using data from this same data set (National Survey of Black Americans [NSBA]) found that as the seriousness of distressing problems increased, so did the use of prayers as a coping mechanism (Neighbors, Jackson, Bowman, & Gurin, 1983).

Religious participation among African Americans, especially women, has been associated with the use of specific types of informal helpers. For example, Taylor and Chatters (1988) found that church members provided a substantial amount of support, including emotional support, to many older African Americans. Hatch (1991) found that attending religious social events was predictive of preferences for nonrelative helpers among African American women, but not among white women. A summary of the work by Taylor and Chatters using NSBA data indicates that church attendance, church membership, subjective religiosity, and religious affiliation were all significantly related to the receipt of support from church members among African Americans (Caldwell, Chatters, Billingsley, & Taylor, 1995). The availability and use of informal helpers for emotional problems and the selection of church members and nonrelatives as helpers have implications for pathways into professional mental health services for African American women. The influence of religious beliefs and activities (e.g., prayer) as well as the reliance on religious social networks for fellowship and emotional support may replace or delay the need to seek professional mental health services among religious women. This issue remains an empirical question because surprisingly few studies have investigated the role of religion in the use of professional mental health services.

Another sociocultural factor that might influence the use of mental health services by African American women is mistrust of the system of care (Neal & Turner, 1991). Sussman et al. (1987) identified fear of treatment and of being hospitalized as the main reasons that African Americans do not seek professional mental health services.

Establishing trusting relationships between professional mental health workers and African American clients can be difficult when feelings of oppression and discrimination are considered (Nickerson, Helms, & Terrell, 1994; Worthington, 1992). The issue of client mistrust of the professional service delivery system is further complicated by evidence that suggests that African American patients are significantly more likely than whites to be hospitalized or diagnosed with schizophrenia or a psychotic disorder, whereas whites are likely to be diagnosed with a personality disorder (Solomon, 1988; Strakowski et al., 1995). African Americans have also been found to have fewer sessions with a primary therapist and more treatment with medications than whites with comparable symptoms (Flaskerud & Hu, 1992). Because much of mental health services are shaped by the values and beliefs of European American culture (Comas-Diaz, 1992; Mays & Albee, 1992), such services may not be perceived as desirable or helpful (Wallen, 1992) by African Americans. This is especially true for those who identify strongly with an ethnic group for whom society has used a variety of tools of oppression, including psychotherapy. Thus, the patterns of professional services use by African American women may reflect sociocultural barriers based on shared ethnic group beliefs.

Consequently, the purpose of this study was to explore the role of sociodemographics, social support, and sociocultural characteristics in African American women's use of community mental health centers and private psychotherapists. In that regard, this study examines the particular importance of sociocultural factors such as religiosity, ethnic group consciousness, and preference for black therapists and cultural sources of social support, such as church networks. Knowing the correlates of black women's mental health service use is necessary for designing delivery systems and research that can effectively meet their needs and expectations.

Method

Sample

Details on the sampling plan for African American women participating in the NSBA can be found in Jackson (1991) and Mays, Coleman, and Jackson (1996). For this particular study, only those women ($N = 455$) who reported

using any type of professional helper in their problem-solving efforts were included for analyses.

Measures

The section of the interview designed to study mental health was problem focused. Respondents were asked to report a personal problem they had experienced that caused them a significant amount of distress. If the person had ever experienced a personal problem of this type, they were asked the nature of the problem. Reliability and validity for these questions were established during the pretest phase of the study. Focus groups and back-translation procedures were used as well as face validity established by a panel of mental health experts (Jackson, Tucker, & Bowman, 1982).

Problem Type. Every respondent who said she had experienced a problem was asked the following question: "Thinking about the last time you felt this way, what was the problem?" This question was designed to ascertain how the respondent conceptualized the nature of the distress experienced. The answer to this question represents the specific locus to which the respondent attributed the cause of her personal distress. For analytic purposes, responses to this question were categorized using face validity and interrater (three clinical psychologists averaging a mean of 3 years post-PhD training) reliability of .90. The problems were classified into five categories: financial, health, adjustment, emotional problems, and other. Adjustment problems referred to problems that could be characterized as temporary and not of a long-standing nature. In contrast, emotional problems were characterized by their long standing and their ability to seriously affect the respondent over a lengthy time period.

Problem Severity. Problem severity was determined by the person's perception of how much the problem interfered with her ability to perform her usual social obligations. Answers to several questions that ranged from feeling at the point of a nervous breakdown to lesser degrees of problem difficulty were obtained. This measure was then dichotomized to represent those women who felt they were at the point of a nervous breakdown as high severity and those at all other levels of difficulty as lower severity.

Professional Help Use. If the respondent had experienced a problem, she was presented with a list of professional helping facilities and asked if she had

gone to any of the listed places for help with her personal problem. The list included the following sources: hospital emergency room, medical clinic, social services, community mental health center, private mental health psychotherapists, private physician's office, minister, lawyer, police, school, and employment agency. For purposes of analysis, the women were categorized into three groups: (a) those who went to a county mental health center (n = 27); (b) those who sought help from a private psychotherapist (n = 46); and (c) those who consulted other professional helpers (n = 382) for a total sample of N = 455.

Sociodemographics variables included in the analyses were standard items of age, education, income, urbanicity, and region. The social support measures (help from church members, family, and friend networks and involvement in a main romantic relationship) and sociocultural variables (religiosity, desire for a black helper, and intention to return for further help) were all single-item measures of either social network involvement and the provision of help or ethnic preferences for professional helpers.

Results

In general, the data indicated that African American women typically seek professional help from sources other than private therapists or community mental health centers. However, the type of problems taken to mental health professionals differed by the type of mental health professional used (community mental health vs. private practice). For example, women with adjustment problems used a variety of sources of help. However, women with financial or health problems were more likely to use private therapists or other resources, whereas women with serious emotional problems relied on community mental health centers (see Table 11.1) As expected, there was a significant difference in the level of problem severity of users of mental health services versus users of other sources of professional help—$\chi^2(2) = 12.37$, $p < .01$. Black women who perceived the problem that precipitated the help-seeking behavior to be at a high level of severity were more likely to use private therapists or community mental health centers than other types of professional helpers (see Table 11.2).

Sociodemographics. Further analyses of the data were conducted to examine the relationships between three categories of variables that previous research suggests might influence use behaviors—demographics, social sup-

Table 11.1 Black Women's Problem Types, by Services Used

	Private Therapist		*CMHC*[a]		*Other*		
Problem Type	*Percentage*	*(n)*	*Percentage*	*(n)*	*Percentage*	*(n)*	*Total*
Adjustment	17.6	31	9.1	16	73.3	129	100%
Financial	10.2	5	6.1	3	83.7	41	100%
Problem difficulty	9.8	4	12.2	5	73.0	32	100%
Health	9.3	5	5.6	3	85.1	46	100%
Total *N*		45		27		248	

NOTE: $\chi^2(8) = 20.49$, $p < .01$.
a. County mental health center.

Table 11.2 Severity of Black Women's Problems, by Type of Service Used

	Private Therapist		*CMHC*[a]		*Other*		
Level of Severity	*Percentage*	*n*	*Percentage*	*n*	*Percentage*	*n*	*Total*
High	13.3	37	7.6	21	79.1	220	100%
Low	5.1	9	3.4	6	91.5	162	100%
Total *N)*		46		27		382	455

NOTE: $\chi^{2(2)} = 12.37$; $p < .01$.
a. County mental health center.

port, and sociocultural factors. Table 11.3 presents the results of the analyses of the sociodemographics variables. In the present sample, only age—$\chi^2(4) = 14.16$, $p < .01$—and region—$\chi^2(2) = 8.91$, $p < .01$—were significantly related to use of a particular type of service. Specifically, older women were less likely to use mental health professionals than any other age group. Regarding region, black women who did not reside in the south used private therapists significantly more than those who did reside in the south.

Social Support. As indicated in Table 11.4, the selected social support items were not important independent factors. However, the relationship variable of main romantic involvement did suggest a possible trend. Black women who had a main romantic involvement were more likely to use mental health professionals than were those who did not have such a romantic involvement—$\chi^2(2) = 4.89$, $p < .10$).

Table 11.3 Characteristics of Black Women, by Type of Professional Help Used For Mental Health Problems

	Private Therapist		*CMHC*[a]		*Other*				
Sociodemographics	*Percentage*	*n*	*Percentage*	*n*	*Percentage*	*n*	*Total*	$\chi^2(df)$	*Cramer's V/ϕ*
Age							14.16(4)***	.13	
18-34	11.5	21	5.5	10	83.0	151	100%		
35-54	12.8	21	5.5	15	78.0	128	100%		
55+	3.7	4	1.8	2	94.5	103	100%		
Total *N*		46		27		382			
Education							7.08(4)	.09	
Less than high school	7.5	15	8.0	16	84.5	169	100%		
High school graduate	10.5	14	3.0	4	86.5	115	100%		
Some college+	14.3	17	5.9	7	79.8	95	100%		
Total *N*		46		27		379			
Personal income								3.62(4)	.07
Less than 5,000	9.0	19	7.1	15	84.0	174	100%		
5,000-9,999	8.7	9	3.9	4	87.4	90	100%		
10,000+	14.3	13	6.6	6	79.1	72	100%		
Total *N*		41		25		336			
Family income								1.79(6)	.05
Less than 5,000	9.4	12	7.0	9	83.6	107	100%		
5,000-9,999	11.0	11	8.0	8	81.0	81	100%		
10,000-19,999	9.9	9	5.5	5	84.6	77	100%		
20,000+	8.2	6	4.1	3	87.7	64	100%		
Total *N*		38		25		329			
Urbanicity								5.80(2)	.12
Urban	11.7	43	5.4	20	82.9	305	100%		
Rural	3.4	3	8.0	7	88.5	77	100%		
Total *N*		46		27		382			
Region								8.91(2)***	.14
South	6.1	14	6.9	16	87.0	201	100%		
Non-South	14.3	32	4.9	11	88.5	181	100%		
Total *N*		46		27		382			

Sociocultural. Religiosity was the only sociocultural factor related to type of service used—$\chi^2(6) = 13.89, p < .05$. Specifically, black women who said they were fairly religious were more likely to use a private therapist, whereas those who indicated that they were not religious at all tended to use community mental health centers (see Table 11.4).

Discussion

This study attempted to identify those demographic, sociocultural, and social support factors associated with specific types of mental health services used by African American women. The most striking finding in this study was the difference in the level of severity of problems between users of the three types of professional helpers. Women with the most severe problems tended to use community mental health centers. Also, when any type of mental health service was used, the problems were more severe than when other sources of professional help were used. This finding suggests that by the time African American women enter therapy, their problems have escalated to a critical stage.

In another study based on this same data set, it was found that African American women tend to combine informal with formal services to a greater extent than do black men (Neighbors & Jackson, 1984). The study described in Chapter 10, however, found that African American women often sought informal help in addition to professional services. Although this may be true, when problems are viewed as very severe, black women do seek professional mental health services.

The results of the analyses for the age variable were not unexpected in the black women in the 35 to 54 age group. They used mental health services proportionately more than did the other age groups. Problems generally associated with the use of mental health professionals must be interpreted in mental health terms before such use occurs. The results of a national replication study on the mental health of the American population by Veroff, Kulka, and Douvan (1981) suggest that younger people are more likely to define problems in mental health terms than are older people.

A finding unique to the present study was that region of the country was significantly related to type of service used. Because data for this study were based on a national probability sample, we were able to analyze the relation between residential region and patterns of service use. African American women who lived in the South were less likely to use private therapists than

Table 11.4 Relationship of Informal Resources, by Type of Professional Services Used

Social Support	*Private Therapist*		*CMHC*[a]		*Other*		*Percentage Total*	$\chi^2(df)$	*Cramer's V/Φ*
	Percentage	*n*	*Percentage*	*n*	*Percentage*	*n*			
Help from church members							4.04(4)	.08	
Often	10.1	11	4.6	5	85.3	93	100%		
Sometimes	10.1	16	4.8	6	86.1	136	100%		
Never	8.7	6	10.1	7	81.2	56	100%		
Total *N*		33		18		285			
Help from family								4.34(4)	.08
Fairly often	9.0	20	5.4	12	85.5	189	100%		
Not too often	12.8	17	4.5	6	82.7	110	100%		
Never	10.3	8	10.3	8	79.5	62	100%		
Total *N*		45		26		361			
Friendship network								4.75(4)	.07
Some	6.7	6	4.4	4	88.9	89	100%		
A few	11.8	38	5.9	19	82.4	266	100%		
None	4.9	2	9.8	4	86.4	35	100%		
Total *N*		46		27		381			
Main romantic involvement								4.89(2)**	.13
Yes	14.6	18	9.8	12	75.6	93	100%		
No	9.8	18	4.9	9	86.3	157	100%		
Total *N*		36		21		250			

Social Support	Private Therapist		CMHC[a]		Other		Percentage Total	$\chi^2(df)$	Cramer's V/ϕ
	Percentage	n	Percentage	n	Percentage	n			
Religiosity								13.89(6)**	.12
Not at all	0.0	0	16.7	1	83.4	5	100%		
Not too religious	8.9	4	13.3	6	77.8	35	100%		
Fairly religious	13.8	(32)	4.3	(10)	81.9	(190)	100%		
Very religious	5.8	10	5.8	10	88.3	151	100%		
Total *N*		46		27		390			
Racial consciousness								2.21(4) .05	
Low	10.1	20	4.5	9	85.4	170	100%		
Medium	10.1	12	5.0	6	84.9	101	100%		
High	11.3	9	8.8	7	80.0	64	100%		
Total *N*		41		22		335			
Ethnic preference for helper								3.05(4)	.08
Wanted black	19.5	8	7.3	3	73.2	30	100%		
Did not want black	6.9	2	6.9	2	86.2	25	100%		
No difference	11.0	15	7.4	10	81.6	111	100%		
Total *N*		25		15		166			
Would go again								2.57(2)	.08
Yes	9.7	37	6.1	23	84.2	320	100%		
No	17.0	9	5.7	3	77.4	41	100%		
Total *N*		46		26		361			

a. County mental health center.
**$p < .05$.

were women in other parts of the country. This finding is not unexpected in that for blacks living in the South, indigenous and community-based resources, particularly church-based sources of help, are frequently used to deal with problems rather than traditional mental health services (Jackson, 1981).

The expectation that social support would be related to the type of service used was not confirmed. Degree of religiosity was, however, significantly related to type of service used by black women. Black women who said that they were not at all religious tended to use community mental health centers in preference to private therapists or other sources of professional help. These women were also the women with the most severe problems. This suggests that these women may be less likely to have helping networks that include organized resources such as ministers, church organizations, or church members. On the other hand, African American women who were very religious used sources other than mental health professionals. It is possible that religious women rely more on ministers and other resources generated from their church network for help with their problems. The institution of the black church has always served as a source of strength, mutual aid, and comfort for black women in their personal struggles (Caldwell, Greene, & Billingsley, 1994; Murray & Harrison, 1981; Taylor, 1986c; Taylor & Chatters, 1988).

An interesting culturally based methodological comment can be made about the lack of significance in the social support variables in the face of finding significance for religiosity. If our study had used, as most studies have, only measures of social support, it would have appeared that social support had little to do with the seeking of mental health services. Yet when religiosity is included, which is a different but culturally understandable way to assess sources of support, particularly for African American women for whom the church and its extended network structure are culturally permissible places to seek help for emotional problems, we learn that religion as a function of its support systems may be a moderator of mental health help seeking.

Learning that those black women who identify themselves as religious tend not to be the ones seeking services for serious emotional problems may be a clue to successful prevention strategies. In the prevention of serious mental illness in African American women, it may be important to consider the role of community-based resources rather than confining ourselves to individually oriented private or community mental health center treatment strategies. Comas-Diaz (1992) suggests that the shape of psychological services for ethnic minorities in the future will include reliance on faith and prayer coupled with a sense that normative self-development includes the spiritual. In a

commentary on the future of mental health services for ethnic minorities in the future, Mays and Albee (1992) see the traditional private practice mode as one infrequently used for the delivery of mental health services in favor of work sites, home, schools, churches, and other commonplace everyday settings.

Several factors investigated in this study proved not to be significantly related to the type of mental health services used by black women. Family or personal income, education, availability of social support, and satisfaction with services received were not associated with the type of professional helper selected by these women. A major limitation of our study was that, although our analyses were based on a national probability sample, less than 75 women had used professional mental health services, thereby restricting our analytic procedures to bivariate analyses. It is not clear whether using a larger sample would result in more significant relationships. It is also not clear from our findings whether the significant relationships found might be explained by socioeconomic factors such as income or education, as other studies have suggested. Multivariate analyses that incorporate sociodemographics as well as sociocultural variables are necessary in future studies to understand adequately the complex relationships between these variables for African American women.

However, one must be cautious about the reliance on sociodemographics alone in predicting patterns of service use for blacks in that studies indicate demographics are less reliable for African American patterns than for whites (Dawkins et al., 1979; Griffith, 1985). Our study indicates that age, region, and religiosity are better predictors for black women. These particular variables may yield better prediction because of their cultural-ethnic relevance. Religion has always functioned as an important coping mechanism for blacks (Neighbors et al., 1983). Furthermore, women living in the South, in contrast to many other regions, may have retained more indigenous health care beliefs that may interfere with their seeking professional help.

One conclusion that can be drawn from our results is that African American women underuse professional mental health services and therefore do not seek help for their emotional problems, except when their problems become very severe. This conclusion is often reached erroneously by some health service researchers who overlook other sources of professional or informal help that African American women perceive as appropriate starting points for problem solving.

It is important to recognize that patterns of mental health service use by African American women are complex. Although we do know several variables, such as education, income, availability of third-party payment sources,

age, and others, that are influential in the choices of treatment, the mixed picture in several use studies makes it clear that other factors are at work. Results of our study call for the inclusion of culturally based factors such as religion and other measures that take into account the unique life experiences, beliefs, and values of African American women.

Recent studies have turned their attention toward the role that naturally occurring social support networks and self-help activities play in help-seeking patterns and individual well-being (Griffith, 1985; Mays, 1985, 1995). A growing body of data suggests that an individual's social support network buffers stress and provides instrumental support that lessens the need for professional mental health care (for a review, see Mitchell & Trickett, 1980). Self-help and common-concern groups are increasing among black women as sources of help for coping with personal problems (Mays, 1985, 1995).

Mental health services research that will distinguish between events amenable to naturally occurring community support systems or other sources of professional help and those conditions for which black women are more likely to need professional intervention is greatly needed. Research that would clarify the types of problems that black women define as severe enough to seek professional treatment for would greatly enhance planning of mental health service delivery and aid in training sensitive minority and nonminority mental health service providers. Mental health services congruent with the needs and cultural patterns of black women are more likely to be successful in their goal of effectively responding to their psychological needs. Comas-Diaz (1992) points out that successful mental health services of the future will need to adapt themselves to the use of integrative and comprehensive frameworks that encompass the realities of the everyday lives of black women and other minorities. Mental health services that incorporate realities such as the importance of racial-ethnic identity in choosing therapists, the importance of religion, and sensitivity to the relationship between racism and discrimination to ill health (Cochran & Mays, 1994; Comas-Diaz, 1992; Mays, 1995; Mays et al., 1996) will improve help seeking and mental health service use for mental health problems (Campinha-Bacote, 1991) for African American women as well as for other minorities.

Note

1. The terms *African American* and *black* have been used interchangeably throughout this article.