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A QUALITATIVE EXPLORATION OF BLACK CHRISTIAN WOMEN LIVING WITH DEPRESSION (169 PP.)

Dissertation Advisor: Kamesha Spates

This study investigates the lived experiences of Black Christian women diagnosed with clinical depression or Major Depressive Disorder (MDD). Depression, sometimes referred to as "voice of the devil" throughout the African diaspora, is often a taboo topic in Christian circles, and particularly Black Christian circles in the U.S. Black Americans are the most religious group yet, encountering the highest rates of chronic depression (Brody, Pratt and Hughes 2018). This reality describes a dark side to religion and points to the paradox that describes protective factors of religiosity and spirituality among Black Christians, who are highly religious and spiritual, yet experience higher rates of chronic clinical depression. Exploration is guided by the following question: 1.) What are the lived experiences of Black Christian women diagnosed with clinical depression? To date, literature has focused primarily on the protective factors that religiosity and spirituality can provide. However, an intersectional framework is seldom used to account for the complex and rich relationship of Black Christian women and mental health in the U.S. The purpose of this study is to address the gaps in the literature by offering a current analysis of Black Christian women's experiences living with depression. To do so, sources of information, experiences, and perceptions of discrimination and depression, as well as help-seeking behaviors, are analyzed and discussed. By exploring the unique experiences of Black Christian women in the U.S. diagnosed with clinical depression, we are positioned to gain greater insight into issues of discrimination and stigma, diagnosis and treatment, and access to care.

A QUALITATIVE EXPLORATION OF BLACK CHRISTIAN WOMEN LIVING WITH CLINICAL DEPRESSION

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by

Brittany C. Watts

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Dissertation written by

Brittany C. Watts

B.A., Wheaton College, 2013

M.Div., Duke Divinity University, 2016

M.A., Kent State University, 2019

Ph.D., Kent State University, 2023

Approved by

Kamesha Spates, Chair, Doctoral Dissertation Committee

Tiffany Taylor, Members, Doctoral Dissertation Committee

Rebecca Catto,

Na'Tasha Evans,

Julie Mazzei,

Accepted by

Richard Adams, Chair, Department of Sociology and Criminology

Mandy Munro-Stasiuk, Dean, College of Arts and Science

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LIST OF ABBREVIATIONS & ACRONYMS USED

BFT	Black Feminist Theory
BFWT	Black Feminist Womanist Theory
MDD	Major Depressive Disorder
NAMI	National Alliance on Mental Illness
SBW	Strong Black Woman Schema
SSRIs	Selective Serotonin Reuptake Inhibitors

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CHAPTER 1: INTRODUCTION

"It's like having heavy rocks tied to your limbs and a constant fog in your brain. It's constant, nagging, and intrusive thoughts."

- *38-year-old, Black Christian woman*

INTRODUCTION

According to a study by Mental Health in America (2020), of the 21 million people in the country with depression, 8.74 percent are Black, 12.72 percent are Hispanic, 17.21 percent are Asian, and 50.60 percent are White. However, while Black Americans have lower prevalence rates of depression, the chronicity of the illness is higher among Blacks (56 percent) than Whites (38 percent) (*see Figure 1*), and as a result, leads to Black Americans experiencing increased functional impairment at higher rates (NIH Statistics 2021, Sohail, Bailey and Richie 2014). Clinical depression, a mood disorder medically termed Major Depressive Disorder (MDD), is an illness that perpetuates feelings like loss of interest in activities that once gave joy, feelings of sadness, altered sleep routines, difficulty concentrating, and suicidal ideation (American Psychiatry 2021). Subsequently, those with depression can experience problems—both physical and emotional—to the point of impairment; parts of one's mind and body are diminished in their ability to function. Over time, the conceptualization of mental health and depression has been expanded to address the impact of social constructs and the role of one's social location.

Centers for Disease Control and Prevention's National Health and Nutrition Examination Survey (2019) found that, in the U.S., more Black and Hispanic individuals with depression experience a moderate to severe impact on their everyday lives (e,g., managing home, work, and relationships) than White respondents. Though a paucity of research remains about Black women with MDD, investigators have found differences among the presentation of symptoms, decreased

access to resources, and multiple stressors (i.e., racism, socioeconomic status, geographic location, etc.) (Walton and Payne 2016; Shulz 2006). Moreover, studies find that detection of MDD can be more difficult among Black women due to comorbidity, somatic and physical functional impairment, and denial of illness (Walton and Boone 2019; Baker et al. 1996; Walton and Payne 2016).

FIGURE 1. Chronicity of Depression Between Blacks and Whites

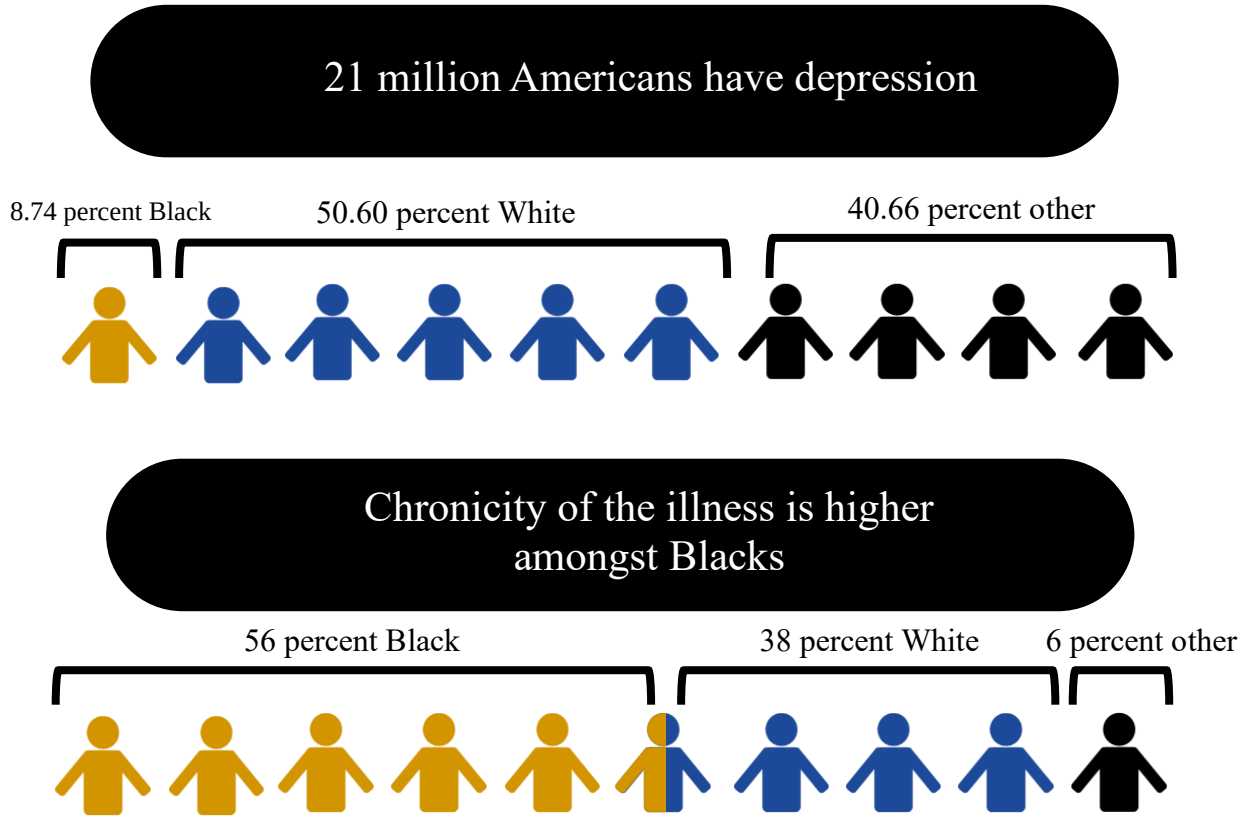

Figure 1: A schematic of the chronicity of depression among Blacks and Whites in the U.S.

BACKGROUND OF THE PROBLEM

Gendered-Racism and Depression

The impact of depression is intensified by racism and stigma within the mental health profession, including lower rates of treatment (Ashley 2014), lower rates of diagnosis (Conner et al., 2010), and cultural insensitivity among healthcare professionals (Clement et al. 2015). In addition, some Black people encounter unique risk factors for depression, like experiencing racial trauma and barriers to access to care (Harris et al. 2020). Understanding the interconnection between race, gender, and religiosity will unfold the specific resources, behaviors, and mental health care needed to affect Black people's mental well-being and everyday lives (Brown 2003, Brown and Keith 2003). According to the U.S. Health and Human Service Office of Minority Health (Statistics 2021), adult Black Americans are 20 percent more likely to report severe psychological distress than adult White Americans; three times more likely to report psychological distress if poor; and more likely to experience feelings of sadness, worthlessness, and hopelessness than White adults and yet have lower rates of clinical depression diagnoses. Structural approaches to both stratification and mental health further this point by finding that groups lower in the social hierarchy will experience more significant psychological problems (Williams and Mohammed 2013a, Williams and Mohammed 2013b), thus, leading to more experiences of symptoms of stress, anxiety, depression, and thoughts of suicide (Lincoln, Chatters and Taylor 2003, Lincoln and Chatters 2003). Lindsay (2019) found from 1991 to 2017 suicide attempts rose 73 percent among Black teens while it declined for White teens.

The impact of overlapping social constructs on one's mental health is pertinent to understanding the scope and depth of the illness, as well as insight into help-seeking behavior

and treatment within one's social and cultural context. The impact of gender and race respectively have been explored in mental health research (Priest and Williams 2018, Read and Gorman 2006) resulting in patterns of gendered differences in experiences and types of mental health disorders. There are several common risk factors that expose women to developing a mental health disorder like lower socioeconomic status, stressful gender-based roles, discrimination, gender-based violence, and abuse (Jackson, Shestov and Saadatmand 2017, Lacey et al. 2015, Perry, Harp and Oser 2013, Thoits 2010, Turner and Avison 2003, Turner, Wheaton and Lloyd 1995). Although women suffer from depression—or depressive episodes—at twice the rate of men, studies have found that women continue to experience obstacles when seeking help due to fear of being stigmatized, not being believed, or having their confidentiality broken (Metzl and Hansen 2014, Muenzenmaier et al. 2015, Thoits and Link 2016). In addition to this, Black women face specific racist-gendered stressors and disparities in health care: 1) lack of quality healthcare; 2) increased rate of chronic diseases; 3) increased maternal mortality rates; and 4) increased blood pressure and heart conditions (Everette, Hall and Hamilton-Mason 2010, Hall, Everett and Hamilton-Mason 2012, Thomas, Witherspoon and Speight 2008, Wilson and Gentzler 2021). Notwithstanding, the Substance Abuse and Mental Health Services Association (SAMSHA), found Black women (10.3percent) are half as likely to seek treatment compared to White women (21percent) (2015 National Survey of Drug Use and Health (NSDUH) Releases).

Mental Health, Religiosity, & Spirituality

Historically, literature concerning Black women and mental health has identified religiosity and spirituality as protective factors against poorer mental health like depressive symptoms (Abu-Raiya, Pargament and Krause 2016, Colbert et al. 2009, Krause 1992, Krause 2006). **Religion** is often defined as a social institution comprised of rituals, beliefs, and

covenants among a group of members (Thoresen and Harris 2002, Miller, William and Thoresen 2003). There is no one definition of **spirituality**, and thus the following will be used for the purposes of continuity and clarity. “Spirituality is a broad concept, with no boundaries, and is not dependent upon a collective or institutional context, although it sometimes encompasses participation in religion. It is an individual search for meaning, connected to one’s most animating and vital life issues and concerns” (Miller, William, and Thoresen 2003, p. 3).

Studying the impact and role of religion and spirituality in the lives of Black Americans is particularly important because, in brief, it’s important to them. A Religious Landscape Study (2014) found that 80 percent of Black women say religion is important to them compared to 69 percent of Black men and 55 percent of White women.

Prayer is a common spiritual practice in the context of health and healing. Fifty-two percent of White adults pray daily compared to 63 percent of Black adults (Mitchell 2022). Specifically, Pew Research (2021) found that 78 percent of Black Americans believe prayer can heal physical illness and injury and 73 percent believe that evil spirits can cause problems in people’s lives (Pew Research 2021). This same study found that 66 percent of Black Americans identify as Protestant, and 67 percent of those are a part of a Black congregation. **Black churches/congregations** are defined as a church that is predominately attended by Black/African Americans and the senior clergy leader(s) are Black/African American (Lincoln and Mamiyah 1991; Mitchell 2022). Moreover, this study (Pew Research Study 2021) found that even religiously unaffiliated Black adults are more religious than unaffiliated adults in general (e.g., likely to believe in God or a higher power; 90 percent vs. 72 percent) and pray at least a few times a month (54 percent vs. 28 percent). When comparing adults who attend services, 62

percent of Black women, 38 percent of Black men, and 37 percent of White women attend services weekly or more (Religious Landscape Study 2014).

Overall, studies have demonstrated positive relationships between religion and mental health. Protective factors that religiosity and spirituality can provide are: stress buffer; coping resource; and healthy behavior influences (Chatters et al. 2015, Dressler 1985, Ellison and Levin 1998, Spates 2014, Spates and Slatton 2017, Taylor, Chatters and Levin 2004). However, the question of whether or not religion has a "dark side" for Black Christians remains to be explored (Upenieks, Louie and Hill 2022). Parallel to the *secular world*, Robbins and colleagues found gender and denominational differences among congregant members that report depression symptoms (Robbins et al. 2020). Other studies have found that religiosity and spirituality can elevate depressive symptoms (Dungee-Anderson and Cox 2000, Taylor and Chatters 2020). For example, Mattis and Grayman-Simpson (2013) found that Black men report greater social support and emotional connection than Black women within their congregation. What remains unclear are the first-hand experiences of Black Christian women in the U.S. diagnosed with clinical depression.

RESEARCH PURPOSE

The purpose of this study is to explore the experiences of Black Christian women diagnosed with clinical depression in the U.S. This study is guided by the following question: What are the lived experiences of Black Christian women diagnosed with clinical depression? A closer look at this unique subgroup yields insight into the systematic and intersecting workings of micro and macro social powers embedded within spaces created for healing: the church and doctor's office. In other words, examining Black Christian women's experiences in this context –

faith and health – further exposes systems of oppression and power against vulnerable groups of people.

SIGNIFICANCE OF STUDY

This study takes a qualitative approach to provide richer detail (Fields 1988), through an open-ended survey categorized into five categories: 1.) experiences living with depression within the Black community; 2.) religion and spirituality; 3.) help-seeking behavior; and 4.) treatment. This is vital because it shows an in-depth overview of Black Christian women's experience with clinical depression, by using their voice, definitions, and experiences (Fields 1988). Additionally it is important because it addresses a gap in the field as few studies have taken an intersectional approach to Black women's experiences, specifically concerning one's religiosity/spirituality and mental health status (Alang 2016, Nelson, Shahid and Cardemil 2020). Therefore because this study focuses on the lived experiences of those with clinical depression, who reside at the intersections race, gender, and religion, it illuminates the intersecting systems of power that impact one's mental health, specifically that of Black Christian women.

This study addresses the gaps in the literature by providing a current analysis of Black women's experience with clinical depression, as well as an exploration of the intersecting systems of status (i.e., race, gender, mental health status, and religion). By examining the experiences of Black Christians with depression, we can understand the depth of resiliency as a foundational belief in the culture of many racial/ethnic populations in the U.S and its impact on their mental health (Browne and Misra 2003). Additionally, this study identifies specific needs and risk factors facing Black women specifically to mitigate issues of diagnosis, help-seeking behavior, and treatment.

ORGANIZATION OF STUDY

Following this introduction, Chapter 2 begins with defining depression and contextualizing its historical and current understandings over time. Subsequently, a brief overview is provided concerning the challenges facing Black Americans and Black women related to depression, as well as the role of religiosity and spirituality for each subgroup starting from enslavement to the present day. Chapter 3 discusses the strengths and limitations of the theories commonly used to frame Black women's experiences in the context of health, religiosity, and spirituality: black feminism, womanist theory, and intersectionality. Chapter 4 outlines the research design and methodology utilized for analysis. The themes from the study are presented in Chapter 5, followed by a comprehensive review in the concluding chapter with a discussion of the results and the study's limitations and implications for future work on Black Christian women and depression and mental health research overall.

CHAPTER 2: LITERATURE REVIEW

DEFINITION & HISTORY OF CLINICAL DEPRESSION

The scientific name for depression is Major Depressive Disorder (MDD). The terminology used for MDD has changed throughout history and social context. For example, in ancient Greece, MDD was originally referred to as melancholia and later coined 'the workings of the devil' (Lloyd-Jones 1965). It was not until the 1970s in the U.S. that depression as a mood disorder was added to the Diagnostic and Statistical Manual of Mental Disorder, and later associated with symptoms such as feelings of depressed mood, lack of interest and pleasure, and significant stress over a period (O'Connor et al. 2009). In Metzl's (2009), *The Protest Psychosis: How Schizophrenia Became a Black Disease,* he provides a scope of the racial-mental health landscape in the 70s, describing the transition of diagnosis and treatment of schizophrenia in America. Schizophrenia transitioned from being a White feminine illness to a Black masculine (read: angry) disease, moving from being disproportionately diagnosed at higher rates from one group (White women) to another (Black men) to maintain social order. Drawing on this history of the intersections of mental illness, race, and gender, Metzl (2009) portrays how the DSM-II functioned as a mirror of the social context and began to "pathologize protest as mental illness" (p.98). In other words, one's social position and cultural context can shape one's mental health perception and experiences.

During the 20th century, sex-type psychiatric categories reinforced "sex roles," utilizing stigma to correct deviant behavior demonstrated by women (Warren 1987). In other words, searching for a cure for mental illness led to the reinforcement of the social role and identity of the mentally ill patient (Goffman 1961). The categorization and diagnosis of depression and frigidity are two ways we see *control* at work in the lives of women (Chesler 2018). Chesler

(1997) explains that the diagnostic tool was based on the level of happiness associated with fulfilling her duties as a wife and mother. Rosenfield et. al (Rosenfield, Vertefuille and McAlpine 2000) found "evidence that the boundaries between the self and others underlie gender differences in mental health which emerge in adolescence and persist through adulthood" (P. 220). The *double jeopardy hypothesis* (Ferraro and Farmer 1996) asserts that those in socially lower-status groups are at increased risk for decreased health. The *triple jeopardy theory* (race, gender, and class) contends that each social identity, when analyzed together, uniquely places individuals at risk of not being able to overcome systems of power and oppression (King 1988).

Studies continue to see patterns of increased diagnosis of schizophrenia and stagnant mood disorders in Black people (i.e., depression) compared to White people (Harris et al. 2020, Muenzenmaier et al. 2015). Therefore, the field of sociology offers an essential contribution to mental health literature because it explores dimensions of depression, as an illness, in conjunction with a group's specific social and cultural context. Freidson (1970) first pointed to the illness as a social construct because of cultural variations in experience, social norms, and cultural competency from medical professionals. Conrad and Barker (2010) build on this theory by bringing into conversation the impact of the professional and their lens. They argue that the general public's understanding of depression is constructed through the lens of "stakeholders and claims makers", not objective truth. Thus, cultural competency is imperative for connection, understanding, and trust. White and Marsella (1982)` call for cultural interpretations of mental health conditions that are interrogated by and through an intersectional framework. Thus, these claims have been vital to exploring the beliefs and attitudes surrounding depression in Black American women.

OVERVIEW OF BLACK AMERICANS WITH CLINICAL DEPRESSION

Between 2015 and 2018, major depressive episodes increased from 9 percent to 10.3 percent in Black youth, ages 12-17, 6.1 percent to 9.4 percent in young adults 18-25, and 5.7 percent to 6.3 percent in 26-29 year-olds (World Health Organization Statistics 2021). Overall, Black Americans report the lowest rates of depression (NAMI 2020), however, they report higher levels of chronic depression and impairment. This is important to further interrogate because of the history of poor diagnosing, lack of treatment and education, and increase of symptoms of depression like suicide, which was the second leading cause of death for Blacks ages 15 to 24 in 2019 (Villatoro 2018, General, Office of the Surgeon 2021). Physical health also intertwines with mental health. Depression is particularly concerning for Black Americans because it is a risk factor for cardiovascular disease, heart disease, stress, and hypertension (Veenstra 2013). The impact of racism on health can be seen through limited diagnosis and reporting of depression among Black Americans (Bell, Williamson and Chien 2008, Loring and Powell 1988, Neighbors et al. 1989), as well as the lack of cultural competency of clinicians and unwillingness to discuss relevant encounters with discrimination (Alang 2016, Bell, Williamson and Chien 2008, Greene-Moton and Minkler 2020). In addition, research points to a lack of understanding of symptom expression across gender (Assari et al. 2018, Hammond 2012) and racial groups (Williams, Cabrera-Nguyen and Johnson 2018), ultimately impacting diagnosis reporting, as well as cultural incompetency related to migration history and nativity status, thwarting connections between the patient and mental health care professional (Doyle, Joe and Caldwell 2012, Jones et al. 2020).

The Black-White paradox in health studies, particularly in the context of depression, describes the lower prevalence rates of depression among Black and non-White Hispanics and

Latinos compared to Whites (non-Hispanic), despite Blacks and Hispanics experiencing greater major life stressors (Williams and Collins 2001). In other words, notwithstanding higher stress exposure, greater material hardship, and poor physical health, Black Americans experience similar or comparatively lowers rates of psychiatric disorders than White Americans. Risk factors include: racism, unemployment, poverty, violence, and residential segregation (Priest and Williams 2018, Taylor, Chatters and Levin 2004, Umberson 2017). This phenomenon has befuddled health researchers, and it remains unclear if this paradox is an invalid finding due to selection bias or information bias, or if it is a true representation of the racial-health patterning of depression in the U.S. (Erving, Thomas and Frazier 2019, Pamplin II and Bates 2021). Nonetheless, there is growing research that explores the complexity of the health paradox. For instance, the Black-White health paradox has been investigated across racial and gender lines in the context of religiosity or belief in God (Thomas Tobin et al. 2022) and the impact coping resources/mechanisms have on the paradox (Louie et al. 2022). However, there is little focus on the Black-White health paradox as it relates to Black women, depression, and the role of religion. Specifically, there is limited evidence explaining the underlying mechanisms that could account for such a paradox. Thus, our understanding of the paradoxical nature of Black-White responses in health is yet to be clarified.

Due to the pervasiveness of macro social powers within racism, sexism, and classism in the U.S., the historical challenges remain current (Brown, Ndubuisi and Gary 1990, Harnois and Bastos 2018, Leupp 2017, Williams et al. 2007). Health information and access to resources like outpatient therapy and prescription for Black Americans have only decreased in usage (Hines, Cooper and Shi 2017, Stockdale et al. 2007, Williams and Jackson 2005), mainly due to stigma (Campbell and Mowbray 2016, Doyle, Joe and Caldwell 2012) and instances of discrimination

(Keith et al. 2010, Williams, Neighbors and Jackson 2003). Campbell and Mowbray (2016) discussed the societal expectation that suggests that Black Americans are resilient and can endure all, so they therefore cannot experience depression, which is tied to fear of stigmatization and can encourage one to hide their illness. Furthermore, having depression can also be viewed as personal weakness, which perpetuates the cycle of silence and stigma (Conner et al. 2010). Undeniably, social barriers intracommunally impede on the cultural dynamics within the Black community.

The Blue Cross Blue Shield Association (2022) found that 54 percent of Black respondents of 2,700 adults believe their community would "look down upon" them for having a mental illness, compared to 38 percent of White respondents. Das et al. (2021) found an 11 percent increase in emergency department visits per 100,000 related to depression among Black Americans following police killings. The impact of police brutality, racial profiling, and a history of distrust between Black Americans and the police force may exacerbate the delay of treatment and, thus, lead to prolonged experiences of silence and isolation. Fndings are parallel to previous studies that find Black Americans to be more likely to seek mental health care from a primary doctor or community member (e.g., pastor, friend, or family member) (Waldron 2019; Baruth et al. 2013, Hurd, Stoddard & Zimmerman, 2013, Lincoln, Taylor, Watkins & Chatters, 2011, Plowden, John & Vasques, 2006).

BLACK WOMEN & CLINICAL DEPRESSION

The legacy of slavery has led to historic and sustaining adversity for African Americans in the U.S. and the African diaspora writ large. The Black body, physically and mentally, has been a source of exploration and curiosity since the colonization of peoples from the African diaspora (de Young 2010). Black women, particularly during the slavery era, were exposed to

varying levels of violence from sexual abuse to beatings. The exploitation of Black women's bodies was legitimized through the creation of fables about Black womanhood (Collins 1990; Hooks 1982; King 1988), suggesting that Black women were uncontrollable, hypersexual individuals whose alleged shortcomings created a racial and gender divide between them and White women (Collins 1990). Systematic racism and discrimination throughout history have continually impeded Black people's health, education, and social and economic capital. For instance, studies find that women are twice as likely to experience MDD, with a 35 percent heritability. In other words, there is a 35 percent chance depression can be genetically passed down, ultimately altering the child's stress response and immune system development (Otte et al 2016). Consequently, what occurs in Black women's bodies can impact the next generation of Black people. The World Health Organization (2021) estimates one in three women (33 percent) and one in five men (19 percent) have major depression by the age of 65 in the U.S. Major depression is a growing disease globally, is predicted to be the leading cause of disease by 2030, and is already the leading cause of disease for women internationally (Albert 2015). Though biological factors (e.g., puberty, postpartum, peri- or menopause) contribute to the specific gendered causes triggering depression in women (Mirowsky 1996, Newhart 2013), the underlying mechanisms that Black women uniquely face are yet to be fully explored.

Black women's experiences, however, are compounded when evaluating racism-related stress (Perry, Harp, and Oser 2013) because chronic and acute stressors linked to sexism impact women's mental health outcomes (Settles 2006, Williams 2018). Studies have also indicated that gender discrimination predicts psychological distress, anxiety, and depression (Berger and Sarnyai 2015, Harnois and Bastos 2018). Moreover, scholars have noted that Black women are highly likely to be exposed to more stressful situations than other marginalized groups

(Aneshensel, Rutter, Lachenbruch 1991; Hatch and Dohrenwend 2007; Pearlin 1999; Umberson 2017). Brown and Keith (2003) reveal that Black women are likelier to have agoraphobia, mania, post-traumatic stress disorder, and nonaffective psychoses across all racial and gender groups. The U.S. Office of the Surgeon General (2001) found that depression, anxiety disorder, and phobia diagnoses occur more often in Black women than Black men. These findings align with previous literature that finds stark differences in gender regarding the rate of diagnoses. Even though general causes of major depressive disorder, for instance, are multiple stressful events, genetics, and/or medication (Roxburgh 2009, Spence, Adkins, and Dupre 2011), the Summary Health Statistics from the National Insitute of Mental Health (2017) shows that Black women continue to experience severe psychological distress at a higher rate than Black men. Also, Black people are more likely to report increased feelings of sadness, hopelessness, worthlessness, and the feeling that "everything is an effort" in comparison to their White counterparts.

STIGMA & STEREOTYPES

The myths about Black slave women manifested into the contemporary stereotypes commonly circulated today. Black women are perceived by society to be overly sexualized (known as the Jezebel); as the help (known as mammies); or rude, loud, and controlling (known as the Sapphire) (Andrews et al. 2017, Ashley 2014, Beauboeuf-Lafontant 2009), all of which are often juxtaposed against stereotypes of White woman, who are depicted as proper, pure, and ladylike (Collins 2000). Research confirms that these stereotypes play a predominant role in negatively impacting Black women's mental health (Donovan and West 2015, Green 2019, Reynolds-Dobbs, Thomas and Harrison 2008). Historically, the mammy figure has been the prevailing image depicted within the setting of White family life in the antebellum South, but this image was later transformed within the context of the Black church. As Green (2003) notes,

"The mammy symbol [was] later rescued from pejorative connotations and reclaimed in some African American churches as mothers of the church" (p. 120). Though the authoritative figures in this space are respected and hold much power, Brown and Keith (2003) note the dangers of fulfilling the same societal needs in both spaces, regardless of racial bounds. Internalizing the image can lead to gender exploitation in various ways.

Strong Black Woman Schema (SBW)

For example, the strong Black woman (SBW) stereotype's origins have been deeply entrenched in the institution of slavery (Abrams et al. 2014) and rooted in stereotypes of Black women mentioned earlier—the welfare queen, jezebel, and mammy—all of which contrast to usual stereotypes of White women—proper, pure, and ladylike (Collins 2000, Wingfield 2007). Walker-Barnes (2014), takes it a step further by describing the SBW schema, which has evolved and transformed into many different names: Superwoman, Modern Mammy, Black Lady, and Sojourner Syndrome (Abrams et al. 2014). Nevertheless, there is one central tenet within all these images: strength, which is analogous to "walking with broken feet" (Walker-Barnes 2014:43).

To date, literature has discussed the SBW schema in regard to harmful health outcomes (e.g., increased stress, development of depression) (Beauboeuf-Lafontant 2009), positive health outcomes (e.g., utilized as a defense mechanism, preservation of self and family) (West, Donovan and Roemer 2010, Woods-Giscombé 2010), and the impact of social media and depictions of Black women on one's perceptions of an SBW (Nelson 2011, Stanton, Jerald, Ward et al. 2017). More specifically, Black women who have identified as embodying the SBW role/ideal report higher levels of perceptions of stress (Woods-Giscombé 2010), increased symptoms of anxiety (Watson and Hunter 2015), depression, irregular sleep (Woods-Giscombé

2010), and emotional avoidance (Watson and Hunter 2016). The Sisterella Complex, similar to SBW, reveals the eruption of feelings of guilt and worthlessness associated with over-sacrificing oneself or not being able to meet the surrounding expectations, and examines how these feelings impact Black women's help-seeking behavior (Abrams et al. 2014).

The SBW schema is a socialized construct, and its internalized perception within Black women manifests in unhealthy ways as it prioritizes the virtue of strength. However, not all Black women disavow the SBW role, though they believe it to be a stereotype that has placed restrictions on Black women (Nelson, Cardemil and Adeoye 2016). Moreover, Black women can be impacted by the SBW schema even if they have not internalized the damaging stereotypes (Stanton, Cole, Ward, et al. 2017). In other words, awareness of stereotypes (pejorative or otherwise), and the understanding that others may judge based on these stereotypes, may generate stress that would have otherwise not existed. Hooks (1992) points to the issues that erupt from overemphasizing strength and writes, "We feel it necessary to keep it all together. Black women are so well socialized to push ourselves past healthy bounds that we often do not know how to set protective boundaries that would eliminate certain forms of stress in our lives" (p. 10). The role of strength in an SBW is not stagnant and remains a salient, gendered ideology that many attribute to Black womanhood (Nelson et al. 2016, Stanton et al. 2017). This misunderstanding is due to the myth that the SBW schema is an alternative to the negative stereotypes (e.g., mammy, angry Black woman, etc.), but as previously mentioned, this role may not be a positive alternative for Black women.

UNIQUE STRESSORS

Across racial and ethnic lines, Black women are more likely to suffer from various chronic mental and physical health conditions than their non-Black counterparts (Bazargan and

Hamm-Baugh, 1995, Simons et al 2021). Black women report higher levels of obesity, diabetes, cardiovascular disease, and hypertension and thus are subjected to disproportionate distress, especially in cases of life-threatening illnesses (Roger et al. 2012). Other components that exasperate single, Black, poor, heterosexual mothers' mental health and depressive symptoms are the "infrequent contact between father and child, the mothers' dissatisfaction with the fathers' financial contributions for the child, and unexpectedly, their satisfaction with their own relationship with the father" (Brown and Keith 2003:168). Tamir et al. (2021) in a Pew Research Study on U.S. Black population find that approximately 30 percent of Black households are headed by single women in comparison to nine percent of White households. A study found a pattern between unemployed mothers and increased stress and depressive symptoms, and the researchers argue that a low-paying job is better for Black women's health than no job in light of this specific context (Brown and Keith 2003). Varied depressive symptoms were also found among unmarried and married African American adults. One study found that married men, for example, experience greater social support than nonmarried men and nonmarried women experience greater social support than married women in religious settings (Williams et al. 2021).

Another stressor Black women face is violence, both historically and currently. Black women are exposed to disproportionate violence, from sexual assault to homicide, that directly impacts their mental health (Crenshaw 1991, Weiss et al. 2017). Black women's social position makes them vulnerable to the underlying mechanisms of social control that upholds a "White, racist, patriarchal society," protects Black men, and denigrates Black women's voices, subsequently perpetuating a culture of silence when in need, whether due to abuse or severe depression (Brown and Keith 2003:153).

When considering the various subgroups within the African/African American diaspora, Miranda and Cooper (2004) finds that the disparity between U.S.-born Americans and African/Caribbean-born women is even more significant. Specifically, she finds that U.S.-born Black women are almost three times as likely to experience depression as African-born women, and 2.5 times as likely as Caribbean-born women. This implies differences in one's culture and nativity on depression (Miranda and Cooper 2004), and highlights the nuances of racist-gendered experiences of those from the African diaspora in the U.S.

Gender differences are evident regarding internalizing problems (e.g., depression) versus externalizing problems (e.g., anti-social behavior), given that women do more of the former than men (Stacey and Thorne 1985, Verbrugge 1985). However, within the context of Black women, when looking at the intersection of *race*—a group of people who share physical or social qualities within distinct categories (Winant 2000)—and *gender*—a set of psychological and social characteristics society considers appropriate for males and females (Butler 2002, Deutsch 2007), Black women have lower rates of both internalizing and externalizing problems (Rosenfield, Vertefuille and McAlpine 2000). Watkins and Johnson (2018) using the National Health Interview Survey, corroborates these studies regarding feelings of nervousness and restlessness. However, Black women are as equally psychologically distressed as White women.

Since race-only and gender-only conceptual models of mental health do not fully apply to Black women, a need exists for a better understanding of the underlying mechanisms of Black Christian women's mental health. Turner and Avison (2003) find that including individual and social stressors provides a comprehensive conceptualization of stress within the context of race, gender, and socioeconomic health inequalities. Psychological distress and similar unfavorable health outcomes are associated with individual and social stressors, especially when stressors

debilitate one's self-concept (Pearlin et al. 1981, Perry, Harp and Oser 2013). Conversely, interventions like social support, mastery, and self-esteem mediate these outcomes (Pearlin et al. 1981). Though this approach is not a new phenomenon within sociology, it is an understudied topic within the context of Black Christians.

DISCRIMINATION

Black women "have historically held multiple social roles, encompassing their personal and family life, community and workplace" (Brown and Keith 2003:207). Thus, Black women have, and continue to carry, the burden of the community health crisis due to limited mental health resources, few culturally competent practitioners, the absence of mental health advocates, minimal discussions of mental health rooted in spirituality, and limited spaces designed to help marginalized individuals (Andrews, Stefurak, and Mehta, 2011, Clement et al. 2015, Okunrounmu et al. 2016, Townes, Chavez-Korell and Cunninham 2009). When considering Black women's social roles within the literature—parenthood, marriage, and employment—one's SES is a significant predictor of mental health (Perry, Pullen, and Oser 2012, Villatoro et al. 2018, Williams and Collins 1995). Perry, Harp and Oser (2013) find that low-SES Black women who encounter increased levels of discrimination are more vulnerable to other individual-level stressors, particularly financial stressors, which remain the strongest. African American women have been underrepresented in higher paid professional positions and have generally occupied lower paying jobs, such as domestic service jobs, that equate to loneliness, decreased pay, and limited or no retirement benefits or vacation opportunities (Collins 1995). Poor mental health as a result of these positions is due not only to monetary needs but also to the limited opportunity to exercise one's talents and experience self-fulfillment (Brown and Keith 2003). On the other hand, Black women seeking higher paid positions often encounter a glass

ceiling; that is, they are blocked from upward mobility and forced into entry-level positions that they are overqualified for (Browne and Misra 2003, Hall, Everett, Hamilton-Mason 2012, Jackson and Stewart 2003).

RELIGIOSITY, SPIRITUALITY, & CLINICAL DEPRESSION

Protective Factors

Representations of religion are born out of shared realities, thus making it a social entity (Durkheim and Pickering 1975). Religion is a source of solidarity, stability, and an essential piece of the social system (Wallwork 1985). Current literature has continued its exploration of the protective benefits provided for someone who is both religious and spiritual. For instance, in the U.S. church attendance prevents early morbidity and deters involvement in the use of drugs, alcohol, gambling, and other risky behaviors (Powell, Shahabi and Thoresen 2003, Strawbridge et al. 1997). Similarly, in the U.S. church attendance supports positive relationships in one's life, which aids in mental health by lowering the risk of experiencing depression and psychological distress (Ellison, Burdette and Hill 2009, Jang and Johnson 2004, Li et al. 2016, Strawbridge et al. 2001, VanderWeele et al. 2016).

Literature suggests that religion can indirectly and directly affect mental health outcomes. For example, participating in religious activities like prayer or worship can encourage positive emotions and a sense of well-being, impacting one's mental health (Chatters et al. 2015, Levin 2009, Taylor, Chatters and Levin 2004). Taylor, Chatters, and Levin (2004) found that praying can promote a sense of calm and peace and ultimately modifies the relationship between religion and stress by providing peace about distressing events (e.g., serious injury, major surgery, etc.) (Mattis 2002). Generally, it is understood that religious involvement includes the following factors: belief in God or higher power, membership in a religious community, and religious

praxis and values. Social resources are also a product of religiosity; members can utilize other members and clergy for social support, which manifests into a buffer against stressful events (Brown, Ndubuisi and Gary 1990). Studies find that participation in the church creates opportunity for community involvement (e.g., community action and political engagement at local, regional, and national levels), which creates a source of empowerment for some (Gilkes, 1985, Gilkes 1998). These findings align with other studies that demonstrate a positive relationship between religiosity and one's psychological well-being (Fenelon and Danielsen 2016, George, Ellison and Larson 2002, Green and Elliott 2010).

Religion is used as a coping mechanism for handling issues such as depression or anxiety. Generally, there are three coping strategies: social support (i.e., seeking comfort from others), avoidance (i.e., physical and/or psychological withdrawal), and problem-solving (i.e., directed strategies to mitigate a problem) (Pearlin 1978). Furthermore, Black women's unique daily life stressors due to disproportionate discrimination in various social settings—such as the workplace, stores, and restaurants—call for use of these specific coping strategies (Brown et al. 2017, Everette, Hall and Hamilton-Mason 2010, West, Donovan, and Roemer 2010) to combat feelings of distress and inadequacy (Thomas, Witherspoon and Speight 2008). According to a study by Ward et al. (2013), Black Americans' coping behaviors stem from internalizing views connected to psychological openness, stigma, and help-seeking.

Literature within social psychology and sociology point to four different intervention strategies: social support, censoring, coping, and religion/spirituality (Lewis 2013, Szymanski and Lewis 2016, Thomas, Witherspoon and Speight 2008). Social support—from family (immediate and extended), friends, and religious community—is one strategy that Black women depend on (Pietererse 2010). Social support is also well documented throughout the sociology

literature because of Black women's disproportionate exposure to primary and secondary stressors (Avison, Schieman, and Wheaton 2009; Lincoln, Chatters, and Taylor 2003; Pearlin 1999, Pullen, Perry, and Oser 2014). Findings indicate that voluntary participation in religious organizations and maintaining relationships with family and friends who make one feel loved and supported are linked to lower depressive symptoms (Krause 2009). Similarly, if relationships are symmetrical, wherein the positives within the relationship outweigh the negatives, it will result in less depressive symptoms (Brown and Keith 2003). This coincides with findings that show that rather than seeking out mental health professionals, African Americans generally will seek the religious counsel of a pastor or rely on prayer to eventually ease their mental health burdens. Although church and religious practices have been a safe zone for African Americans since slavery, relying on them completely can be detrimental when structured therapy or pharmaceutical intervention is required (Wilson et al. 2018). Some studies, however, argue that African Americans may have lower rates of depression compared to non-Hispanic White Americans due to the resilient nature of the community and heightened religious support.

Negative Factors

Contrary to the metanarrative within the sociology of religion on Black Christian experiences, one's faith can be compromised through the practice of religiosity. Lincoln, Chatters, and Taylor (2003) explains that, "A single snapshot of the life stressors facing Black women may not be sufficient to understand the potential role that private religious behaviors play in addressing these difficulties on an ongoing basis" (p.236). Black women's relationship with the church has always been complicated, yet the gray nature of this relationship is not often reflected in the investigations of their experiences in the church, nor its complex impact on mental health/illness.

For instance, Brown and Keith (2003) find that Black women who feel surrounded by criticism and demanding work/people are more likely to report symptoms of depression. Higginbotham (1993) says that Black women feel like they have given more than received in their friendships compared to White women. Thus, further analysis of social support and friendships cultivated in the church should continue to, since studies have found that African American women receive less support from other congregants than men (Taylor and Chatters 1988, Taylor et al. 2017). Taylor and Chatters (1988) posit that this outcome could be related to male status and the issue of visibility for Black women. Lincoln and Mamiya (1990) describe the Black church as vessel for Black people to establish status, experience racial pride and community, and build political platforms, particularly for Black men.

Still, even these studies agree that these patients often tend to be underdiagnosed or misdiagnosed (Shepard Payne 2012, Walton and Shepard Payne 2016, Woodward et al. 2013). Studies that depend on the protective factors of religiosity and spirituality without analyzing the mitigating factors working against the resiliency framework may not fully encapsulate the complexity of the social experience and its impact on Black Christian women's mental health (Balkin et al. 2022). It is important to note here that not all Black women are Christian nor participants of a Black church—Black religious life is rich with diversity—but for the purposes of this study, and because Black women are the most faithfully attending religious group across gender and racial lines of any racial/ethnic group in the U.S. (Pew Research 2021), and rates of depression are increasing for Black women (NAMI 2020), this study focuses on the lives of Black Christian women.

The Black Church

The Black church was directly opposed to racism and other forms of violent oppression. The church manifested into an object of resistance, a space for the socially marginalized, and a voice both by and for the oppressed. It is a central part of the Black experience in the U.S. Defining the Black church can be complicated and remains a source of debate. For this study, the Black church is defined as a predominately Black congregation (Lincoln and Mamiya 1990) regardless of its affiliation with a historically Black denomination or not. When the term "Black church" is used, it is to be understood as a "sociological and theological shorthand" for the pluralism of churches (Lincoln and Mamiya 1990:2). Du Bois (1903) was one of the first to analyze what was then referred to as the "Negro Church" and its effects within and outside of the Black community, and described the Black church as a manifestation of survival. He explains that the Negro Church was the only social institution for Black people, born from the roots of Africa, survived enslavement, and "preserved in itself the remnants of African tribal life and became after emancipation the center of Negro social life" (P. 1). The Black church sits at the center of Black experiences.

Ironically, the Black church's fight against racial oppression did not include advocacy for women's rights, thereby developing a hierarchical stratification ladder that even today places women at the bottom (Yeary 2011). Du Bois (1903) noted this disparity in his analysis of the Black church through his descriptions of the Black church's sense of community and ability to block racism from entering the sanctuary (Zuckerman 2002). Nevertheless, Campbell and Winchester's (2020) study of Black churches in the Midwest found that the Black church is positioned to meet the community's needs by working to reduce stigma and offer mental health services. Additional current discussions and resources provided for mental health have taken the

form of educating cultural leaders, like barbers (Carlton et al. 2021), with the hopes of disseminating information to community members. Health and well-being have historically been defined as inclusive of physical and spiritual aspects of self. Therefore, churches have a central role in how their congregants view formal sources mental health care (Wharton et al 2018).

The next chapter presents the three sociological theories that are best used in research on health, religion, and spirituality concerning Black women: Black Feminist Theory, Womanist Theory, and Intersectionality. Additionally, it includes a brief discussion of Womanist Theology and how this theological framework will inform greater understanding of Black Christian women's experience. Following this, in Chapter 4, the data utilized for the study is outlined, as well as the mode of analysis. Chapters 5 through 8 discuss the emerging themes, how they are defined, their relevancy, and their purpose regarding the research question "What are the experiences of Black Christian women with clinical depression?" The final chapter includes a discussion of the results and a summary of the study's limitations, implications, and future research.

CHAPTER 3: THEORETICAL CONTRIBUTIONS

Black feminists and Womanists recenter the voices of Black women in their articulation and study of complex systems of domination that work over and against Black women's bodies. Alice Walker's book, *In Search of Our Mothers Garden* (1983), delineates the relationship between womanism and feminism, "*Womanist is to feminist as purple is to lavender*." Walker describes womanism as a larger ideology that concerns itself with gender equality, while feminism is thought to be integral to this work. The following discussion includes an overview of Black Feminist Theory (BFT) and Womanist Thought: specifically, how Black feminist and womanist scholars have shifted the paradigm in which we understand social systems of power. Moreover, this discussion shows how these bodies of thought created an epistemological and ontological shift in our understanding of interlocking systems versus binary thinking (Collins 1989). This chapter's discussion builds on how Black Feminism Womanist thought (BFWT) serves as a catalyst for intersectional analysis, which is the understanding of the multiplicity of oppressions and the intersections of social domination. For a complete breakdown of key components of each theory see "Table 1. Overview of Black Feminism, Womanism, Womanist Theology, and Intersectionality."

BLACK FEMINIST THOUGHT (BFT)

Though it was born from exclusion, Black feminism rose in the 1800s and was embodied by Black women like Sojourner Truth who asked, "Ain't I a Woman?" challenging racism and sexism (1851); Anna Julia Cooper, champion of social change and education (1892); and Ida B. Wells, activist and crusader against lynching during the late 1890s. Dill (1983) posits that within the U.S., White feminists stalled the feminist movement across racial and class lines due to racial discrimination and prejudice. Further examinations of the role of racism in the feminist

movement are narrated by Black feminist scholars (Davis 1981, Hooks 1982, Hooks 1984). This type of bifurcation parallels the different realities Black and White women face day to day in the U.S.

Despite the obstacles that face Black women, and subsequently Black feminism, Black feminists—thinkers and activists alike—have called into question binary thinking to articulate the complexity of Black women's lived experiences. Collins (1990) explains that this influences social change within the academy and on the ground level and is represented in the range of Black feminisms. For example, black feminism includes liberal (Collins 1990, Nash 2018), radical (Brewer 2003, Brewer 2021, Carruthers 2018), trans (Jackson 2021), and queer feminisms (Ja'nina, Broussard and Garrett-Walker 2019). Liberal Black feminists aim to reform existing systems, whereas radical Black feminists seeks to dismantle existing systems articulating an anti-capitalist, anti-racist, anti-heteropatriarchy, and anti-imperialist agenda. Carruthers (2018) articulates liberation and its importance to Black radical feminists by explaining that Black women's oppression can only cease through the dismantling of systems that propagate "-isms" (i.e., racism, sexism, capitalism). In other words, Black women's freedom is predicated on the destruction of oppressive systems and creation of one that centers liberation for all. Black feminist bell hooks (1984) defines this form of praxis as the embodiment of opposition to White supremacy, capitalism, and patriarchy. Though not all Black feminists' objective is to tear down capitalism, all Black feminism recognizes and fights against the practice of discrimination by race and gender in the lives of Black women.

Black feminism in the U.S. has influenced the study of race, class, and gender within academia. Collins (2000, 2004, 2015) notes the diversity of social justice projects by Black feminists in the 1960s and 1970s that sought to undo social inequalities perpetrated both

domestically and globally. Ultimately, Black feminism seeks to embolden Black women through critical analysis of "how mutually constructing systems of oppression of race, class, gender, and sexuality framed the social issues and social inequalities that Black women faced" (Collins 2015:8). However, the pervasive issue of legitimacy of the utilization of Black feminism as a theoretical framework within the sociological field remains (Collins 1998, Cooper 2015) and is often overshadowed by the predominant gender and race theories when describing the mental health and general health inequalities experienced by Black women.

WOMANIST THEORY

At the core of Womanism is a holistic understanding of oneself as a woman (Walker 1983). Alice Walker (1983) defines a womanist as committed to the "survival and wholeness of entire people, male and female. Not a separatist, except periodically, for health… Loves music. Loves dance. Loves the moon. Loves the Spirit. Loves love and food and roundness. Loves struggle. Loves the Folk. Loves herself. Regardless" (P. 1). Womanists are committed to the well-being of all people, and most importantly, are aware of their value. Womanism is interwoven into the fabric of the Black political struggle toward liberation (Walker 1983).

Current scholarship that examines Black gender is present in discussions of politics and contributions from the Crunk Feminist Collective (Cooper 2020, Cooper, Morris and Boylorn 2016), and Womanist Theology (Townes 1995, Turman 2013, Williams 1993). The Crunk Collective, for instance, embraces Black culture, encouraging self-care and empowerment—foundational concepts to Womanism. Within the context of spirituality, Health (2006) defines womanism, as "a way of living, a form of social witness, used for critiquing society; for affirming dignity and self-worth; for achieving sanity, communal solidarity, and social support; as well as a way for distinguishing the oppressed from their oppressors" (p. 161).

Rousseau (2013) describes the three foci of womanism: 1) asserts race matters to Black women; 2) acknowledges race and gender analyses must happen simultaneously; and 3) maintains the struggle toward equality between Black women and men. Although scholars have claimed womanism to be another term for Black feminism (Collins 2000), others like Phillips and McCaskill (2006) define this framework with its respective goals, characteristics and methods that draw similarities to Black feminism, but offer a unique perspective (*See Table 1* "Overview of Black Feminism, Womanism, and Intersectionality"). Black women's social location is central to Womanism because it is understood to be the catalyst toward solutions and social change (Phillips, McCaskill, and Lemons 2006). Moreover, womanism considers the intergenerational impact our lived experiences can have; thus, it examines survival strategies utilized for communal balance, nature and the spiritual world (e.g., mothering, self-help, and using spirituality as means for problem-solving) (Phillips, McCaskill and Lemons 2006).

Utilizing Black Womanist-Feminist Theory (BWFT) provides a dual lens and highlights the nuances of Black Christian women's lived experiences of depression. Specifically, these frameworks center on Black women's experiences. Womanist theory is a theoretical framework developed by Black women for Black women and articulates insights from the perspective of Black women. Ultimately, it is a theory seeking to empower Black women to be the arbiters of dismantling intersecting systems of power that work over and against them (Banks-Wallace 2000, Collins 2000, Townes 1996). BFWT is grounded in a collective cultural understanding of and interactive impact of social constructs on Black women (e.g., race, class, gender, etc.). These frameworks contextualize Black/African American Christian women's experiences and perspectives (*see Figure 2*).

Figure 2. Diagram of Black Womanist Theory, Womanist Theology, & Intersectionality: Illustration of how the following theories capture Black Christian women's experience: Black Feminism, Womanism, Womanist Theology, and Intersectionality.

WOMANIST THEOLOGY

The first to use "Womanist Theology" as a term was Delores Williams, a first-generation womanist theologian, in her 1987 article titled "Womanist Theology: Black Women's Voices". Townes (2003) expounds on the origins of Womanist Theology, pointing to Womanist theologian Katie Cannon's (1985) article, "The Emergence of Black Feminist Consciousness," as a seminal piece in understanding the framework. Cannon outlines the following key elements of Womanist Theology:

1. Centers Black women's survival in a classist, racist, and sexist society
2. Provides a framework to interrogate the role of the Black Church (including the use of scripture to reinscribe social systems of domination)
3. A portrayal of organizational strength led by Black women
4. A social critique of racial stratification focused on Blackness
5. Social justice-based spiritual advocacy
6. Incorporation of ecological issues
7. Concern for health, sexuality, and labor

Womanist Theology branches across disciplines, fostering epistemological and ontological contributions, especially to social sciences (Avent Harris et al. 2021, Balamani 1997, Coleman 2022, Wimberley 2015). However, most scholarship concerning the experiences of Black women through a womanist lens come from Womanist (Protestant Christian) theologians (Townes, 2003). Womanist theologians provide words, experiences, and explanations that the social science field has yet to investigate because they wrestle at the crossroads of being a Black woman and child of God in a space that socially and systematically mirrors oppressive regimes of the *secular* world (Barnes 2006, Gilkes 1996).

In the seminal book *Sisters in the Wilderness: The Challenge of Womanist God-Talk,* Williams (1993) challenges the use of Black Liberation Theology to describe the juxtaposition of Black women's lived realities, asserting in the wilderness is where you will find and understand the Black women's lived experience. Black Liberation Theology emerged in the early 20th century, led by James Cone, to contextualize Black Americans' struggle toward freedom and assert that God is with and for the oppressed (Cone 2018, Cone 1997). Williams' (1993) interpretation of Hagar's story is in response to Black Liberation Theology, which centers the Exodus biblical narrative to demonstrate decisive intervention by God on behalf of the oppressed. However, Williams' (1993) understanding of Hagar, Black women's experiences, and the church, de-emphasizes authority from a male-figure while simultaneously empowering Black women. Williams uses the biblical narrative of Hagar, an Egyptian slave of Sarah and Abraham, to explain survival and quality of life. Hagar's story is interpreted as a biblical example of Black women's oppression, resistance, and ultimate liberation.

Theologian Kelly Brown Douglas (1999) discusses sexuality, gender roles/norms, and the role of respectability politics in the Black church by connecting the prevalence of the narrative of civility in Black churches and communities to Whiteness, power, and exclusion of non-normative bodies. Respectability politics controls how the church functions and, most of all, how the church is gendered (Cooper 2017, Pitcan, Marwick and Boyd, 2018, White 2001). Coleman and Maparyan (2013), third-generation Womanists, propagate that Black women should not have to be "respectable" to be accepted by the Black church. To do so would be antithetical to the foundational concepts that ground and sustain the Black church today. Nevertheless, the church has relegated Black women to a subordinate position in the church, deeming them less than

others and seeking spiritual transformation and liberation, and at times outside of the church walls (Benbow 2022).

As previously mentioned, Womanism allows Black women to participate (holistically) in the theological processes that have typically been dominated by men within religious conversations (Mitchem 2014). Mitchem (2014) defined womanist theology as: **"**the systematic, faith-based exploration of the many facets of African American women's religiosity. Womanist theology is based on the complex realities of black women's lives. Womanist scholars recognize and name the imagination of initiative that African American women have utilized in developing sophisticated religious responses to their lives". (P. 1)

Therefore, using BFWT and Womanist theology in mental health research is fitting because it includes participatory witnessing (Black women's narrations of experiences) and an ethic of care (recognition of their experiences) (Banks-Wallace 2000, Townes 1996). In, *Breaking the Fine Rain of Death: African American Health Issues and Womanist Ethic of Care* (1998), Emilie Townes investigates Black health and health care through a dual lens: social ethics and ethic of care based on the biblical book of Joel; and understanding of race, class, and gender. Townes expounds on the social systems that impact individuals and groups and relationships among people, ultimately asserting that understanding health involves a holistic approach: emotional, biological, and spiritual; and, that health is interwoven into our social realities. Black women's conceptualization of mental health embraces both the social and cultural contexts of its relationship to one's mind, body, and spirit (Borum, 2012). Furthermore, it enables Black scholars to investigate the specific and unique experiences of Black women without "being guided by what White feminists have already identified as women's issues'' (Taylor 1998, Williams 1989:181-82).

INTERSECTIONALITY

Intersectionality, as a term, was introduced in the 1980s by Kimberlé Williams Crenshaw to bring attention to the differences and similarities within the context of antidiscrimination and social justice. Through the lens of critical race theory, Crenshaw (1989) investigated discourse on antiracism and feminism concerning women of color who are victims of sexual violence; ultimately Crenshaw (1989) argues that both racism and sexism work together as interlocking systems of domination that disproportionally affect the lives of Black women. This disruption of quality of life happens on three levels: structurally (the convergence of systems of oppression), politically (subordinate groups facing challenges due to conflicting political agendas), and representationally (acknowledgment of power relations that challenge and provide strength) (Crenshaw 1989, Crenshaw 1991, Crenshaw 2010).

Patricia Hill Collins (1990) created the sociological paradigm known as the *matrix of domination,* that examines Black women's societal positionality, specifically, issues of oppression as result of racism, classism, and sexism. This concept is situated in the context of institutional discrimination faced by Black women in the U.S. due to their race, and gender. This framework discusses how systems of oppression are organized, and no matter which constructs are entangled, "structural, disciplinary, hegemonic, and interpersonal domains of power reappear across quite different forms of oppression" (Collins 2000:18) and likely result in specific stressors facing Black women—both episodic and chronic (Beatty Moody, Brown, Matthews, and Bromberger 2014).

Intersectionality works to dismantle normative thinking around social constructs and power within the realm of law and politics, knowledge and production, and the fight for social justice. Collins and Blige (2015) emphasize the important contribution Crenshaw (1989) made in

naming intersectionality as a term. But warms against "coining" as being synonymous with origins, see Frances Beal's essay "Double Jeopardy: To Be Black and Female," published in 1969 as a pamphlet, which (Hong 2008) posits as a foreshadowing of intersectionality because it examines racism, sexism, and capitalism as social processes. "Intersectionality's history cannot be neatly organized in time periods or geographic locations. Tying authors to particular decades and schools of thought, far from being neutral, divides history into periods which often leads to oversimplified explanations" (Collins and Blige 2015, p. 63). This is particularly important because intersectionality was born in response to the specific challenges Black women face as a subordinate in each social movement throughout history that fought for liberation (Collins and Blige 2015).

Intersectionality goes beyond the oppressed versus oppressor binary seen in BWF theory and challenges the underlying mechanisms of power and control. Intersectionality is both a theory and an *analytical tool* that requires both critical inquiry and critical praxis (Collins and Bilge 2016). Critical praxis refers to how "people, either as individuals or as part of groups, produce, draw upon, or use intersectional frameworks in their daily lives" (Collins and Bilge 2016: P. 32). Intersectionality considers identities like race, gender, class, and other similar categories as socially constructed and best understood together rather than in isolation from one another.

For Black women, this means that "the intersection of racism and sexism factor into Black women's lives in ways that cannot be captured wholly by looking at the race or gender dimensions of those experiences separately" (Crenshaw 1991: P.1244). When evaluating race and health, scholars have noted the Black-White paradox over the years; this metaphor is used to capture why Blacks may experience more stressors, but there are decreased reported rates of

depression than Whites. However, this paradox has seldom been investigated untilizing an intersectional lens. Applying intersectionality as an analytical strategy enables greater analysis and nuance of depression in the lives of Black Christians (Collins 2015, Collins 2019).

Intersectionality's integrative nature recognizes that multiple oppressions coexist simultaneously and argues that these mutually constructing identities underlie interlocking systems of power and oppression (Collins 2015, Collins and Bilge 2016, Crenshaw 1991). Collins' (2015) seminal piece provides six guiding assumptions:

1. Race, class, gender, sexuality, age, ability, nation, ethnicity, and similar categories of analysis are best understood in relational terms rather than in isolation from one another.
2. These mutually constructing categories underlie and shape intersecting systems of power; the power relations of racism and sexism, for example, are interrelated.
3. Intersecting systems of power catalyze social formations of complex social inequalities that are organized via unequal material realities and distinctive social experiences for people who live within them.
4. Because social formations of complex social inequalities are historically contingent and cross-culturally specific, unequal material realities and social experiences vary across time and space.
5. Individuals and groups differentially placed within intersecting systems of power have different points of view on their own and others' experiences with complex social inequalities, typically advancing knowledge projects that reflect their social locations within power relations.

6. The complex social inequalities fostered by intersecting systems of power are fundamentally unjust, shaping knowledge projects and/or political engagements that uphold or contest the status quo. (p. 14).

Varying usages of intersectionality as an analytical strategy, however, speak to scholars' differing interests and preferences toward certain guiding assumptions (Collins 2015; Collins 2019). Collins (2015) describes the phrase *race/class/gender* as a placeholder in the 1980s for the theoretical framework later named *intersectionality*. Several social justice movements began under this umbrella term and others were later identified as also a part of the movement toward intersectionality (Collins 2015; Cho, Crenshaw and McCall 2013). Collins explains, "Given the size and breadth of the community of women's studies practitioners, the acceptance of race/class/gender studies within women's studies also explains the rapid spread of race/class/gender studies across disparate disciplines" (p.10). Cho, Crenshaw, McCall (2018) point to this tension and how it revolves around intersectionality's "capacity to do any work other than to call attention to the particularities of Black women" (p. 788). Historically, Black women have had to negotiate being both hyper-visible and invisible simultaneously in their everyday lived experiences.

A limitation of the theory is the conceptual understanding of the matrix of constructs. Scholars note the issue of "the additive and autonomous versus interactive and mutually constituting nature of the race/gender/class/sexuality/nation nexus; the eponymous "et cetera" problem" (Cho, Crenshaw, and McCall 2013, p. 787). In other words, the number of social categories and subjects to be considered by an intersectional approach is questioned, as well as the "static and fixed versus the dynamic and contextual orientation of intersectional research" (Cho, Crenshaw, and McCall 2013, p. 787). Nevertheless, intersectionality has been able to

address the needs and identify central interlocking mechanisms of power within a society, ranging in impact on a micro- (individual) to macro- (institutional) level, as well as contributed across disciplines both conceptually and theoretically. Shields (2008) further contextualizes intersectionality and the role of identities saying, “We are not passive ‘recipients’ of an identity position, but ‘practice’ each aspect of identity as informed by other identities we claim” (P.302. Intersectionality confronts the web of social constructs, communities, systems, and power that impact everyday lives. The centrality of the theory and its practicality as an analytical tool to address other oppressed communities or social power is the core of intersectionality.

I do want to note, that it is not coincidental that Black women are the leading scholars in Black Feminist theory, Womanist theory, and Intersectionality, but all three frameworks face obstacles to legitimacy from the academy. Thus, its ability to branch and evolve is stunted. For example, Settles et al (2019) discuss the challenges of epistemic exclusion in psychology, where intersectionality is most often formally and informally excluded creating barriers to social issues scholarship and halting efforts toward social justice in the field. Utilizing the three/four theories in this study seeks to continue to give agency and legitimacy not only to the voices of Black Christian women but to the Black women in the field of sociology, academia, and the public *doing the work.*

Table 1. Overview of Black Feminism, Womanism, Womanist Theology, and Intersectionality

	BLACK FEMINISM *(Collins 2000)*	**WOMANISM** *(Phillips, 2006)*	**WOMANIST THEOLOGY** *(Williams 1986)*	**INTERSECTIONALITY** *(Collins and Bilge 2016, Crenshaw 1989)*
PURPOSE	empowerment self-definition	social change, activism, ending all forms of oppression	Black women's survival, a framework to critique the Black church, model of organizational strength, advocacy for justice-based spirituality	considers all social constructs as underlying mechanisms of power to identify and dismantle systems of oppression
GUIDING ASSUMPTION	African American women share the common experience of being Black in a society that denigrates women of African descent	Black womanhood serves as the origin point for a speaking position that freely and autonomously addresses any topic or problem		intersecting social constructs create unique experiences, opportunities, and barriers
CHARACTERISTICS	lived experience as a criterion of meaning, use of dialogue in assessing knowledge claims, ethic of caring, ethic of personal accountability	anti-oppressionist, vernacular, nonideological, communitarian, spiritualized	Multidialogical intent, litgurcal intent, didactic intent, and commitment to reason and female imagery	social inequality, intersecting power relations (structural, disciplinary, cultural and interpersonal), social context, relationality,

			and metaphorical language when construction theological statements	social justice, and complexity
VALUES	everyday intellectuals, lived experiences, within group diversity, outsider within status, communal mothering	everyday experiences and problem solving, dialogue, cultural harmony, self-help and mutual aid, arbitration and mediation, spirituality, motherhood, healing	conversations with diverse people and backgrounds, proactive theology relevant to Black Church, Black Church's response to justice, quality of life and survival, language that encapsulates complexity of systems and actors	everyday lived experiences, social justice, self, and communal empowerment

Adaption From Lindsay-Dennis, Lashawnda (2015) "Black Feminist-Womanist Research Paradigm: Toward A Culturally Relevant Research Model Focused On African American Girls." Journal of Black Studies, p. 510.

CHAPTER 4: METHODS

PURPOSE OF STUDY

This study examines the experiences of Black Christian women living with depression. Though previous studies have explored the connections between Black women and mental health, scholars have mostly investigated the positive impact and protective factors associated with religious and spiritual participation. This project, however, brings another layer of context—religion—to the lived experiences of Black women living with depression. This study includes Black women's accounts of their experiences with depression and the role of religion and spirituality in their lives. Using the following theoretical frameworks: Black feminist theory, womanist theory, and intersectionality, the underpinning mechanisms impacting women living at the crossroads of race, gender, and religion within the Black community is explored. By studying Black Christian women's experiences, we can better understand the lived experiences of an understudied group: Black women living with clinical depression.

DATA & RECRUITMENT

This project used secondary data from a majority open-ended questionnaire collected through Qualtrics, an online survey platform. The data was collected to examine the experiences of Black/African Americans living with depression in the U.S. More specifically, the study focuses on Black Americans' perceptions and experiences of depression, treatment plans, attitudes, and barriers to help-seeking/support, as well as the role of religiosity and spirituality. The Kent State University institutional review board approved the research.

A convenience sample approach was utilized to recruit Black women and men 18 years of age and older and diagnosed with clinical depression (n=261). Qualtrics, an online software tool and sample aggregator, recruited participants using the following mediums: permission-

based networks, customer loyalty web portals, social media, gaming sites, website intercept recruitment, and targeted email lists. A third-party, through Qualtrics, verified participant eligibility measures (i.e., name, address, and date of birth) before the participants could join the Qualtrics panel (Miller et al. 2020). Those who identified as Black/African American, 18 or older, and diagnosed with clinical depression were eligible to continue.

Data were collected between June 5, 2019 to October 30, 2019. Once participants began the survey, they had the opportunity to stop participation at any time. Those who discontinued the online survey received a direct link to the National Alliance on Mental Illness (NAMI) if they needed additional resources. Only de-identified data from Qualtrics was received and used to maintain anonymity.

Qualitative research is especially useful for reaching greater depths of understanding that cannot be obtained through quantitative methods alone (Aspers and Corte 2019). In doing so, Black women's words—voices--are centered. Thus, this research follows the guiding premise of Black Womanist Feminist theory (BWF) that identifies Black womanhood as the point of origin that freely and independently can address any topic or problem (Cooper 2015, hooks 2000). This is particularly important to qualitative research because it decenters the researcher's viewpoint and investigates through the lens of the participant (Sosulski, Buchanan and Donnell 2010).

A total of eight themes were on the questionnaire: 1) Sources of information about depression; 2) Experiences living with clinical depression within the community; 3) Perceived discrimination about depression within the Black community; 4) Perceptions of clinical depression; 5) Perceptions of mental health therapy; 6) Treatment; 7) Help-seeking behaviors; and 8) Religion and spirituality. For the purposes of this study, the following five themes were analyzed: 1) perceptions of clinical depression; 2) experiences living with clinical depression

within the Black community; 3) treatment; 4) help-seeking behaviors; and 5) religion and spirituality.

Following the questionnaire, participants were asked the following demographic questions: 1) Hispanic, Latina, Spanish origin; 2) Gender; 3) Sexuality; 4) Year of birth; 5) State currently residing; 6) Relationship status; 7) Education level; 8) Annual household income; 9) Employment status; 10) Religion; 11) When they were diagnosed with clinical depression; 12) By whom (primary care v mental health clinician); 13) Race of primary medical or mental health provider; 14) Racial preference of provider; and 15) Type of insurance. The total sample response rate was (N=1168), but due to eligibility criteria and incomplete responses, the total was reduced (N=261). The gender breakdown is as follows: women (N=169) and men (N=92). *See Figure 3* for more details.

FIGURE 3. Diagram of Coding Phases

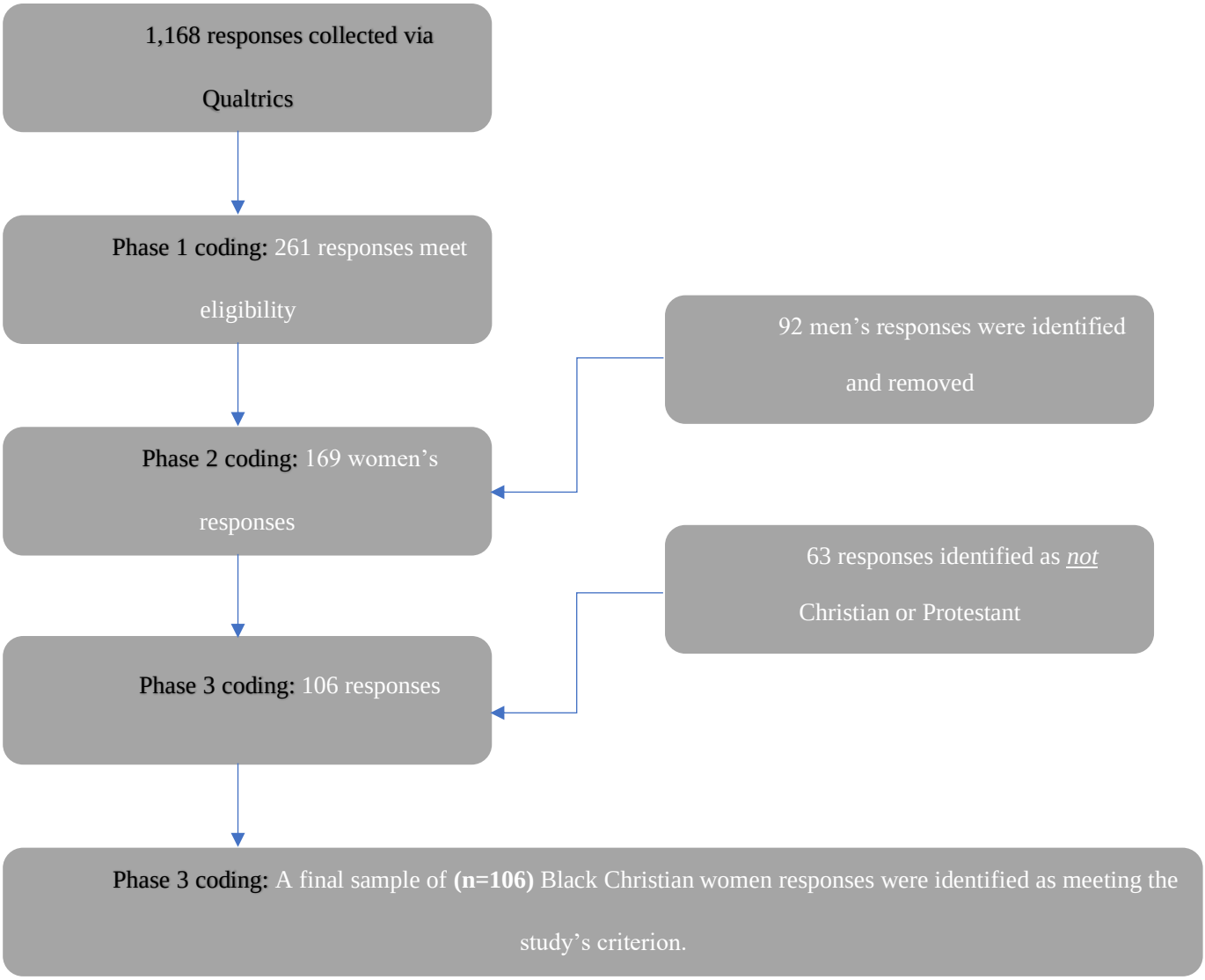

Figure 3: Workflow of sample responses based on inclusion criteria.

SAMPLE

Inclusion criteria were: self-identify as Black/African American woman; 18 years of age or older; diagnosed with clinical depression; Christian/Protestant; and residing in the U.S. As a result, the total number of eligible respondents was 169; however, the focus was on those who

identified as Protestant (N=13) or Christian (N=93), anyone who identified as, Catholic, Buddhist, Hindu, Muslim, Jewish, Mormon, Agnostic, or Atheist, which brings the total sample to (N=106). Catholics and Orthodox Christians were excluded from the study. Though both are branches of Christianity, their orthodoxy differs from Protestants. A recent Pew Research Study (2021) found that Black Catholics make up less than 4 percent of Catholic adults in the U.S. and feel their religious beliefs and practices differ from those of Black Protestants.

The sample is unique as it includes current and past members of religious/faith-based organizations (current (N=56) and past (N=50), which also accounts for the missing cases when analyzing religiosity and spirituality. The age range of participants was 18 to 71 years old with the average age of participants being 38. Marital status was reported as single (N=59), single with a partner (N=12), married (N=21), legally separated (N=2), divorced (N=8), and widowed (N=4). Based on the 2020 U.S. Census and historical migration of Black Americans over the centuries, this sample is representative of the Black American experience: Midwest (N=18), Northeast (N=13), Southeast (N=46), Southwest (N=20), and West (N=9). See *Table 2* for participant demographic information. Due to the sample's homogeneity and the study's narrow focus, the sample size likely met saturation (Hennink and Kaiser 2021, Sebele-Mpofu 2020).

There are several strengths of this dataset. One, relative to most studies, is that this is a large qualitative dataset on the experiences of Black women diagnosed with clinical depression. Additionally, the validity of the dataset is an advantage because of the study's chosen methodology, sample and data analysis (Silverman 2021). Moreover, the inclusion of both open and close-ended questions, not only allows for rich and in-depth data, but for data triangulation to be possible. Data triangulation is possible due to utilization of both the qualitative and quantitative data (see Appendix A for "Survey Questions").

Table 2. Sample Demographics

VARIABLE	CHARACTERISTICS	*N=106*
Ethnicity	Black/African American	106
	Hispanic (non-white)	5
Sexual Orientation	Heterosexual (straight)	94
	Gay or lesbian	5
	Bisexual	6
	Other	1
Region	Northeast	13
	Southeast	46
	Midwest	18
	West	9
	Southwest	20
Religion	Protestant	13
	Christian	93
Marital Status	Single	59
	Single but living with partner	12
	Married	21
	Legally Separated	2
	Divorced	8
	Widowed	4
Employment Status	Employed	53
	Self-employed	11
	Out of work for 1 year or more	2
	Out of work for less than 1 year	2
	Homemaker	5
	Student	10
	Retired	9
	Unable to work (Please describe)	14

Educational Status	Graduated High School	47
	Associate Degree	26
	Bachelor's Degree	21
	Master's Degree	7
	Doctorate/Professional Degree	4
	Did not complete High School	1
SES	Less than $10,000	14
	$10,000 to less than $15,000	14
	$15,000 to less than $20,000	7
	$20,000 to less than $25,000	4
	$25,000 to less than $35,000	10
	$35,000 to less than $50,000	23
	$50,000 to less than $75,000	17
	$75,000 or more	17
I was diagnosed with clinical depression…	Within the last year	15
	1-2 years ago	24
	3-5 years ago	20
	More than five years ago	47
Who diagnosed your clinical depression?	Primary care physician	48
	Mental health clinician	53
	Other	5
What type of insurance do you have?	Medicaid/ Medicare/ Governmental Insurance	50
	Health insurance (including insurance from your work or your husband's/partner's work)	42
	None/ Personal income (cash, check, or credit card)	13
	Other (Please describe)	1

DATA ANALYSIS

This study utilized a phenomenological framework. In doing so, the goal was to provide an in-depth description that enhanced the understanding of the phenomenon's essence (Husserl 1970, Lester 1999, Wojnar & Swanson 2007). The main aim of phenomenology is to provide a

description based on the way things are as clearly as possible (Lester 1999). Moreover, it is important for the researcher to describe the targeted groups' experience the way it was experienced (Husserl 1970). However, the challenge to such an approach is acknowledging the role of bias and its impact on the interpretation of the phenomena. To minimize the impact of researcher bias, findings were discussed with advisors in the fields of sociology and public health. Results were reviewed in the context of the literature and theory to minimize the risk of misrepresenting the statements provided (Crowther and Thomson 2020).

Phenomenological research is a mode to identify the structure, meaning, and form that create our lived realities. Since the research procedure was an open-ended inquiry into participants' experiences perceptions, it is consistent with phenomenology. Specifically, this study accepted participants' contributions as having equal value for the questions asked, thus patterns and themes that gauged their lived experiences with depression were identified. Open-ended surveys allowed participants to name salient themes—participants' core meanings and not distant objectives (Davis 1971, Eberle 2012)—rather than a close-ended format with fixed responses (Geer 1988). However, the close-ended responses were utilized for descriptive and contextual purposes. The following describes a five-part approach to the implementation of phenomenology:

1. Sense of the whole. One reads the entire description to get a general sense of the statement.
2. Discrimination of meaning units. Once the sense of the whole has been grasped, the researcher returns to the beginning and reads through the text once more, delineating each transition in meaning

3. Transformation of subjects' everyday expressions (meaning units) into psychological language.
4. Synthesis of transformed meaning units into a consistent statement of the structure of the experience.
5. Final synthesis. The researcher synthesizes all statements regarding each participant's experience into one consistent statement that describes and captures [of] the essence of the experience being studied (Giorgi 1985, Giorgi 1997, Giorgi and Giorgi 2003).

Braun and Clarke's (2006, 2015) thematic analysis is often used in qualitative analysis but because its' process is similar to phenomenology, and involves the researcher familiarizing themselves with the data to later identify common themes and patterns (Guest, MacQueen and Namey 2011), phenomenology was identified as the best approach for analysis. Thus all responses were read to get an understanding of the whole narrative, themes and patterns are identified (using participant definitions/labels for those when able), and subthemes are grouped to reveal relationships within codes and patterns (Aspers and Corte 2019). Emerging themes are translated into "psychological language" (when applicable), followed by assigning theme definitions and descriptions. As mentioned previously, descriptive statistics are used to summarize the information; specifically, used to contextualize their experiences and perceptions of depression. The following themes were identified: experiences living of depression; perception of Black community responses; help-seeking behavior; and treatment. The subsequent chapters outline the development of themes/names and relevancy.

RESEARCHER POSITIONALITY

As the investigator for this dissertation, I serve as the single assessor, and as one of the many instruments used during data collection and analysis, it is essential to identify the

researchers' positionality (Reyes 2020). Most importantly, Pillow (2003) encourages researchers to locate one's purpose of contextualizing one's social location and identify the limits of reflexivity. That said, it is important to share my position as a researcher to understand how my shared experience informed my analysis. To implement a reflective attitude, the act of questioning one's pre-understanding is pertinent. Through this lens, the researcher is prompted to shift from general understandings of everyday life to a more self-reflective positionality with regard to the data (Pillow 2003).This form of inquiry enables one to become more aware of one's assumptions and encourages reflections based on the context of the research.

That said, I was born in the Northeast region of the U.S. and raised in a Black Baptist Church. I am the daughter of a Pastor and First Lady. My entire life has comprised of participating in church life, from serving on the usher board at 10 years old to just about every ministry locally, regionally, and nationally (e.g., choir, dance, drama, finance, youth, prison ministry, Sunday school, National Baptist Convention, etc.). My parents, their parents, and their parents have dedicated their lives to service for the Christian body. Thus, my participation and connection to, and within, the church started long before I could conceptually understand. My connection to the Black church only strengthened through age, exposure, and education. In my undergraduate studies I was determined to learn about all religions, challenging the Christian ethic I was raised on and seeking a broader understanding of the role of religion in the lives of everyday people. I went on to graduate with a Master of Divinity degree and have since served through volunteering, preaching, counseling, and teaching in historically Black churches, predominately White churches, and across denominations.

Through it all, a common idiom in the Black church, I can stand here and say I am a Black woman, trained theologian, and doctoral candidate, and I too struggle with chronic major

depressive disorder. I believe my positionality positively contributes to this study because of my unique lens framed by my intersectional lived experience, thereby allowing me to understand and study *lived religion* that includes and centers people's experiences (Ammerman 2014, 2016).

CHAPTER 5: RESULTS

Due to this study's guided methodology, phenomenological analysis, and chosen theoretical frameworks (BFWT, Womanist theology, and Intersectionality), it is imperative that the voices of Black Christian women with clinical depression be heard. My goal in aiding this endeavor is to present Black women's opinions, experiences, and feelings as it relates to their experience with depression. Examples of such subjective perspectives can be found in the labeling of themes and subthemes throughout the study as applicable. The text of quotes is presented verbatim as typed by participants, including typos. The frequency of excerpts is portrayed in parenthesis, and close-ended questions are discussed in relation to the related themes (see Table 3 "Description and Frequency of Participant Themes").

Table 3. Description and Frequency of Participant Themes

(n=106)

Theme		**Description**	**Example Quote**	**Frequency of Excerpts**
Experiences Living with Depression	*Sadness & Loss of Interest*	expression of decreased participation in daily activities, withdrawn, loss of energy, unhappiness, and mood swings as result of diagnosis	I get randomly sad. I feel like I'm worthless. I feel like I don't amount to anything and I feel like I'm a burden to my family and friends.	93
	Impairment & Suicide Ideation	describes inability to physically move, set goals for the future, and suicide ideation as result of diagnosis	It's hell on Earth. It's like being trapped in a gigantic black hole. It feels like your drowning and	62

			nobody will help you. They just watch. You feel like it's not going to get better and you get pretty damn tired of people telling it will.	
	Dread & Shame	expression of feelings of fear, anger, embarrassment, and lack of self-worth as result of diagnosis	I feel guilty that I can't just deal with life sometimes I don't understand why I feel this way when I don't want to.	50
Sharing v. Privacy	*Disclosure of diagnosis*	describes selective sharing about their diagnosis with close family and friends	My mom is the only person I told. I knew she would understand.	142
	Non-disclosure of diagnosis	describes people and reasons why a participant chooses not to disclose to their diagnosis	Everyone and anyone people look at u like u are looking for attention or want to play victim	100

EXPERIENCES LIVING WITH CLINICAL DEPRESSION

The themes related to symptoms of depression were feelings of sadness and loss of interest, dread and shame, impairment, and suicide ideation. Themes related to Black Christian

women's experience with clinical depression are discussed in the context of their disclosure status: sharing v. not sharing. Specifically, participants describe whether or not their diagnosis is shared within the Black community. Within participants' descriptions of living with depression, Black women discussed issues related to relationships and comorbidity. Participants were asked, *can you describe your experiences living with depression?* They were also asked, *what were your personal thoughts about being diagnosed with depression?* To both prompts, the top symptom related to depression was sadness and loss of interest in participating in activities they once enjoyed doing (93).

Sadness and Loss of Interest

One woman described the "up-and-down" nature of her depression and its' subsequent impact on her quality of life. She shares,

> My life has been up and down. Why did I just quit my job? I felt no one such as family and friends, understood. I would have highs and lows and tell myself I wasn't crazy. In fact, I'm known for being a smart, Honor student throughout school and college, but I would have times of great Depression and suicidal thoughts even when I didn't have issues that needed solutions.

Similarly, the women reflected on the chronicity of the illness. One woman said, "My depression comes and goes. It started very early for me, around 12 years old. It really got bad when I went to college at 18. It keeps me from really exceeding in life." Others also shared a similar sense of difficulty in everyday management with symptoms of depression. A participant described it being "difficult at times trying to keep up a happy appearance when all you want to do is cry." Participants also reflected on their loss of interest and participation in everyday activities. For instance, one woman said her depression keeps her from,

> …being able to function, bathe, or cook. Feeling of wanting to escape my thoughts and body. Mask-like sensation over my face when it is really bad. Not enjoying anything. Wanting to be alone but wanting to feel love at the same time.

Others shared similar feelings of decreased interest and loss of energy in participating in daily activities. “You feel so dark and empty. Like, sad. And you definitely feel more exhausted. Things in your health also change.” Women reflected on their issues of co-occurring mental health illnesses, like this woman who deals with depression and anxiety; she said,

> I have issues with always being tired and don't want to be bothered. I suffer from social anxiety. I have panic attacks and sometimes feel angry and upset with myself because I feel like I can be further in life. It affects me often. I'm always worried something is going to happen to me. I always see the bad before the good.

Another woman shared,

> I've always been very sensitive. My depression includes anxiety. I have a bleak outlook; it's been hard for me to set long-term goals because I see life as too unpredictable, futile, and meaningless. I have low energy and spend most of the day isolated in bed. I often think about dying.

Others reflected on their symptoms as it related to the impact it has on relationships with family and friends. One woman described, “Depression has stolen a lot of time away from my family. Every day it's like I'm fighting a war with myself. I never know when a low point will come.” Similarly, another woman described the impact on her family and self-esteem, she said, “I get randomly sad. I feel like I'm worthless. I feel like I don't amount to anything, and I feel like I'm a burden to my family and friends.”

Impairment & Suicide Ideation

The second symptom related to depression is impairment and suicide ideation (63). This is defined as a challenge or physical inability to move physically or mentally, specifically responses related to the inability to physically engage in everyday activities and apathy towards one's future. Suicide ideation ruminates throughout personal reflections of experiences with depression. One woman described living with depression as all-consuming and disruptive of her mind, body, and soul; she said:

> I understand why I have been diagnosed with this. You see, I live inside of a grey fog. Everything is quite literally de-saturated in my vision and washed out in colors. I have an interest in things, but if I fail to act on this interest, I am then grieved by my emotions, and my self-talk isn't at all loving. Depression is like a roach; it hides in the corners of your head and only comes out in the dark. But once you see it, once you act on it, it swarms, trying to hide. Sooner or later, it gets tired and just consumes all of you. Your brain becomes its host, and it pumps depression out into your veins, and then it consumes your heart.

Similarly, another woman described depression as analogous to having an out-of-body experience. She said,

> It's like living in a totally different time and space. It sometimes forces me to shut nearly completely down. Once depression begins to set in, it always takes me all the way back to my early childhood, reliving every painful and traumatic moment I've experienced up until the present time.

Others reflected on feelings of exhaustion that impact their ability to get out of the house or even their bed. One woman shared,

> Living with depression sometimes gets very tiresome. There are days that I do not want to get out the bed, have no communication with any human being, and on some days, I don't get out of bed and do not answer the telephone or door.

Another explained the visibility of her illness, saying, “I limit the amount of days I leave home and go out in public; my depression is recognizable in my body language around strangers and family relatives inside our home.”

Others have also shared experiences of suicide ideation and suicide attempts due to their struggles with depression as it relates to past trauma in their lives. For instance, one woman reflected on the impact of the loss of her mother at a young age and family expectations. She said,

> I lost my mother at age 17, my mother had me out of wedlock and was ashamed of me and other family members made me feel less than a person because of this. After my mother died I went to live with a family member who wasn’t very educated and problems began. I am now 67 years old and have tried to kill myself , I constantly wonder if death is better. I have been committed to a behavior facility once

Another woman shared similar sentiments of sadness and suicide ideation, stating, “I want to die most of the time. The only thing keeping me living is my children.”

Dread & Shame

Feelings of fear, anger, embarrassment, and worthlessness were expressed by participants as a symptom related to depression (50). One woman summarized her experience by saying,

> To be brief: I want to die every hour of every day. It's gotten to the point where going outside results in extreme feelings of low self-worth, my self-esteem is shot by the smallest things, and I often feel like a bother when I go to any store at all.

Another shared, “Living with depression has a way of replacing your confidence with pure anxiety and self-hatred.” One woman compared her depression to being “sometimes worse than being physically ill.” Others described the shame and embarrassment associated with being a woman *and* having clinical depression. “I felt like I was being tagged as the female with depression.” Another asked, “How did this happen to me? I was always so proud and strong.” Whereas another woman added “It was swept under the rug as a weakness on my part.”

Sharing v. Privacy

The subthemes related to disclosure (142) and non-disclosure (100) of diagnosis are broken down by relation to participant: family, friends, health care clinician, spouse/partner, strangers, everyone/“not hiding it,” and no one (*see Figure 3. Sharing v. Privacy*). Of the 106 Black Christian women polled in this study, 87.7 percent said they have shared information regarding their depression diagnosis with someone, whereas 12.3 percent said they have not. Participants were asked: 1). *Have you shared information regarding your depression diagnosis with anyone? If so, who*? 2). *Is there anyone that you have intentionally not told about your diagnosis? Why?*; 3). *How did others respond to finding out about your depression diagnosis?;* and 4). *What advice have you received from your friends, family, or community members regarding how to deal with your depression diagnosis?* To these questions, participants discussed their reasons for sharing or not sharing their clinical depression diagnosis. The top two reasons for non-disclosure are privacy and fear of judgment/not being believed.

Participants described selective sharing of their diagnoses (142) within the following categories: family (77), friends (51), everyone/ "not hiding it," spouse/partner (24), and health care clinicians (18). For instance, participants described the support of their family; one respondent emphasized this notion by saying, "My family, they really really really helped me with my depression." Another shared, "My daughter has always been understanding so has my sister." Others explained, "I did not tell anyone but Family & Friends because I could depend on them they could help me with medicine and make sure that I do not miss my appts."

Some women reflected on the impact that sharing one's diagnosis with others can have; for example, a participant said she disclosed her diagnosis with her "potential partners, close friends, and boyfriends and also the children [she] use to work with so [they] could connect on a deeper level." Another woman reiterated this sentiment explaining, "when depression is finally revealed, the other black person is relieved that he/she can talk freely about their own feelings to a person that looks like them." On the other hand, some women shared out of necessity. One woman stated,

> It's not really something I go around telling people, but if it is someone I know as a friend or family, it only makes sense to mention it, especially in asking them if they think I am depressed.

Another woman shared, "I haven't told anyone. Afraid I'll get judged. Nobody really knows except for my doctor." This form of selective disclosure is also manifested in relationships among peers. Women described withholding sharing their diagnosis to friends. For example, one woman said she did not "want them to think something was wrong." Another said she intentionally does not disclose her mental health status with her peers whom she said, "look

up to me and admire me. They see me as strong, and I don't want to seem weak to them." One participant communicated that she has not shared her diagnosis with anyone; she said, "I keep it to myself. Most people I know don't look favorably on mental illness, although opinions are changing."

Reasons for Non-Disclosure

Of those who have chosen not to disclose their diagnosis, the top reasons were privacy (32) and fear of judgment/not being believed (39). One woman explained, "There are seven people who know about my diagnosis; I am a private person, so only that small number of people know about my depression." Others acknowledged a separation between their private life and work life. One woman said, "I don't mention it at job interviews because they like to hire positive people."

Others withhold sharing out of fear of being judged or not being taken seriously; for instance, one woman said she had not shared with her immediate family because they will "label" her, whereas another was "afraid and don't want to be looked at differently." Another woman shared, "No one knows about my depression except my husband and a few of my family members. They did not take it as being serious." Similar sentiments of not being believed was shared by one participant who said they have intentionally avoided telling "religious bible thumpers [who] will accuse it of being a demon and not seek to help me get help."

Participants also described the fear of losing a partner or being unable to sustain a relationship as a result of sharing. For example, one woman shared, "I haven't told my boyfriend. I haven't told him because I feel like he might break up with me." Similarly, another participant shared that she does not share with "boys that [she's] in to because [she] feels like they won't like [her]; also some black people because it's not as talked about in that community."

PERCEPTION OF BLACK COMMUNITY RESPONSES

Themes related to the perception of Black community responses (319) to Black Christian women's depression diagnosis were as follows: supportive; "Black people don't get depressed"; and belief in mental illness, God, and prayer (see Table 4 "Description and Frequency of Perception of Black Community Responses to Diagnosis and Subthemes"). Within participants' perceptions of community responses, Black women discussed issues related to advice given or lack thereof related to their depression diagnosis. Participants were asked, "*what have been the most common perceptions shared with you from other Black people about Black people who are diagnosed with depression?"*

Supportive

The top community response noted by participants was support (96); which includes descriptions of expressed concern by others, care for one's well-being, and sense of enhanced connection between the sharer and receiver. The subthemes related to community support of one's diagnosis are advice on how to treat clinical depression (52), and the common idiom "take it day-by-day" (37). One participant described an interaction with her mother,

> One evening just inside the house talking while I was playing arcade, online games, my mother did give me advice to not think negative thoughts and always keep a positive mind.

Another participant shared, "they said they will always be there for me and that it would be okay." Others reflected on the impact of their sharing and vulnerability influencing others' ability to identify and get help. For example, one woman said that community responses had been "Understanding and then acknowledging that they have had some feelings which they may need to seek help." On the other hand, participants noted the juxtaposition between a show of

concern/support and a lack of understanding of the illness. One participant used sarcasm in her description of advice provided by others in the Black community regarding her depression diagnosis. She shared, “My favorite piece of advice: 1. just try being happy. 2. you're much too negative; if you were positive, it would improve. 3. You're still sad? Ugh, do drugs! 4. Pray it away.” Another participant shared, “Most of them told me that it was just sadness, but others knew it was different. They tell me to just take it one day at a time.”

“Black people don’t get depressed”

The second top community response to depression describes the taboo nature of depression among the Black community (77). Participants described stigma, the difficulty in discussing their illness, and relatability to others. One participant connected the historical hardship and the expectancy of Black Americans to be resilient and strong to the stigma associated with depression. She said,

> Black people don't get depressed or shouldn't be depressed because our enslaved ancestors had it a hell of a lot worse than blacks today. So, suck it up and stop whining and be the strong black woman you're supposed to be. It's like if just one black person says they're depressed than that's the one black person who is making all black people look weak. There is shame and embarrassment attach to depression.

Another shared,

> A lot of Black people are too judgmental of each other. They see this illness as a sort of stigma. Unless we go through something, ourselves, or have a family member who has suffered through it; we tend to treat it as something like leprosy, or something that's evil. Sometimes, we criticize and fear things we don't understand.

Others shared the difficulty in sharing their diagnosis within the Black community because they have hidden the diagnosis and/or impact of their illness from others. For example, one woman shared that, “Most were surprised by the revelation [her diagnosis]. I tend to put on my game face & act like everything is okay around everyone.”

Belief in Mental Illness, God, & Prayer

Participants were asked the following question, *Are you a member of a religious or faith-based organization?* A total of 53 percent said yes, and 47 percent said no. Therefore, the following results in this subtheme reflect responses only from those who are a part of a religious organization (n=56). Of this subgroup, participants were asked, *do the leaders and or members of your organization believe in mental health diagnoses and treatment? Why or why not?* The top community responses for belief in mental illness (49) are categorized as *yes, <u>because</u> God is manifested through the medical care system* (27), which includes descriptions of the church’s support and advocacy for mental health care and spiritual need. Whereas the second group is classified as *yes, <u>but</u> it should be addressed spiritually* (18), which describes the church, God, and/or prayer as the sole arbiter of healing for mental illness.

Yes, because God is manifested through the medical care system

For example, participants described that their church encourages treatment by offering group sessions or counseling. One woman said, “They believe that sometimes you require extra help other than religion.” Others referenced the role of God when seeking treatment; a participant explained that “God come[s] through others to help those in need.” Another woman shared that her pastor led the discussion of depression by sharing his journey. She said, “My pastor at that time also dealt with depression. The church eventually added licensed counselors.”

Similarly, another participant noted that her pastor "happens to be a police officer. So he knows the importance of recognizing depression etc."

On the other hand, some were a part of religious organizations that still struggle with how to address mental health concerns. One woman shared at her church, "Some of them that are a bit radical may not believe. But I do believe that majority believe that mental health diagnoses and treatment are beneficial." Whereas, another woman explained a generational difference in acceptance of mental health. She said, "Some of them believe in it and some do not. The older members don't, but, the younger ones do."

Yes, <u>but</u> it should be addressed spiritually

Participants described the church's lack of support of the mental health care system and their emphasis on mental illness being a product of spiritual warfare. Belief in God is used as a tool to address one's need for healing. For example, one woman said, "If you are depressed, black people think it is something that can be handle with prayer and assuring that everything will be okay by giving it to God." Another woman added personal growth in faith as mode of healing as well saying, "the Baptist Faith Does [believe in mental illness] because the minister said that we all goes through Challenges and it does take Faith to bring us through." On the other hand, participants described it as being "very hard to tell sometimes" where their church stands on mental illness. Whereas others were told "God is all we need" or "They think it's demons every single time. It's ludicrous!"

Participants were asked, *Has a member of your religious organization ever told you to use prayer as a means to deal with your depression? If yes, by whom?* A total of 57 percent said yes, and 30 percent said no. The two main groups that encouraged prayer were clergy and congregant members (23) v. family and friends (9). One woman said, "I was told by my family I

should pray more because stressing is not of God. I should seek professional help and get treated with medication. Find a therapist to talk to about my issues." Another woman shared a similar takeaway from her community, but her suggestion placed emphasis on the role of Jesus; she said she was told, "Jesus is healing, and he can do all, and prayer works in any situation."

Table 4. Description and Frequency of Perception of Black Community Responses to Diagnosis and Subthemes

(n=106)

Theme		Description	Example Quote	Frequency of Excerpts
Perception of Black Community Responses to Diagnosis	*Supportive*	participant describes others' sense of concern, care for well-being, and connection	They were very supportive of me and my medical condition. Also showed much compassion and concern.	96
	"Black people don't get depressed"	includes descriptions of Black community not talking about illness and being dismissive	Black people don't get depressed or shouldn't be depressed because our enslaved ancestors had it a hell of a lot worse than blacks today	77
	Belief in Mental Illness, God, & Prayer	perceptions of church's support/understanding of mental health care	God puts people in places to help people like me	27*

		and role of health care system		
		perceptions of church's lack of support of the health care system, and emphasis on spiritual warfare	No. They believe mental illness is demonic	18*
** Only participant responses who are a part of a religious organization (n=56) are captured in the theme "Belief in Mental Illness, God, & Prayer."*				

HELP-SEEKING BEHAVIOR

Participants were asked the following question, *Have you been or are you currently being treated for your depression diagnosis?* A total of 81 percent said yes, and 19 percent said no. Themes related to help-seeking behavior (89) were classified as 1). seeking a "sounding board" (71), which includes a need for a trusted person to hear and work through life's challenges as a result of their clinical depression; and 2). regaining control of life (51), which describes the participant's urgency to change circumstances by reducing depressive symptoms and enhancing one's quality of life (see Table 5 "Description and Frequency of Help-Seeking Behavior and Subthemes"). Participants were asked, *What services were recommended to you from healthcare professionals to help treat your depression? Did you use those services? Why or why not?* Participants were also asked, *what are your top three reasons for seeing a counselor or therapist?*

Seeking a "Sounding Board"

Participants were asked, *Do you feel that seeing your counselor or therapist has helped to improve your symptoms of depression?* Approximately, 58 percent said yes, 14 percent said no, and 29 percent do not see a counselor or therapist. Participants emphasized a need to be heard and understood as part of their healing and coping journey. One woman said she sees her counselor to "receive advice for daily life situations, understanding depression, and overcoming symptoms of depression." Another respondent shared her thoughts on her counselor's methods and having someone walk along the journey with her,

> It helped to get what I was going through. I think that her methods and tactics for me to deal with depression helped me a lot. One. They let you speak and be heard. Two, they really care about your healing and take into account like what you've dealt with. Three, it's better to see a counselor to get healing than to be dealing with mental instability alone.

Another participant shared the impact of a judgment-free zone, she said,

> Just talking right now helps me work with my family better. I'm playing with my kids more. I get to talk my problems out to her without judgment. I'm talking, laughing, and smiling.

Participants also shared the benefits of having a sounding board; one woman shared, "Seeing a therapist helps me to see why I am or get depressed. Talking to a therapist keeps me from doing something irrational." Another respondent added, "She helps me fight through the negativity and try to get me to live a happier positive life."

Regaining Control of Life

Participants described a sense of urgency and need for change that motivated them to seek help. One participant shared, “1. I wanted to change my quality of life. 2. I recognized that I could not do it alone. 3. Recommended by my primary care doctor.” Another participant explained, “I want live. I want the joy put back in my life. I want to be able to function in life, even on a bad day.” Similarly, participants shared their battle with suicide ideation and intrusive thoughts that motivated them to seek help. One participant shared, “I used to feel so depressed that I did not know what to do I wanted to kill myself but not anymore. I still have my moments, but the feeling is not strong anymore.” Another participant described, “I was so depressed I felt suicidal. I knew I had to get help asap. Life was a burden for me.”

Other women described a need to seek out assistance due to experiencing compounding illnesses. For example, one woman said she has “post-traumatic stress syndrome, anxiety attacks, and suicidal thoughts.” Another woman explained, “I was depressed. I needed help. Made me realize there were traumatic experiences in my past that caused depression.”

Table 5. Description and Frequency of Help-Seeking Behavior and Subthemes

(n=106)

Theme		**Description**	**Example Quote**	**Frequency of Excerpts**
Help-seeking Behavior	*Seeking a "Sounding Board"*	describes need for a trusted person to hear and work through life’s challenges	The first reason for seeing a therapist is the counselor is a good "sounding board" for me. The	71

			second reason is receiving suggestions from her on fun activities I could do to decrease my depression. The third reason is because we have common respect for one another.	
	Regain control of life	participant describes urgency for help to reduce symptoms of depression and enhance their quality of life	My doctor recommended me to see my therapist and I was so depressed I felt suicidal. I knew I had to get help asap. Life was a burden for me.	51

TREATMENT

After analysis, themes related to types of treatment (311) were discussed in the following subthemes: perception and use of medication or selective serotonin reuptake inhibitors (SSRIs), therapy/counseling experiences, coping mechanisms, and barriers to treatment (see Table 6 "Description And Frequency Of Treatment And Subthemes"). Participants were asked the following questions regarding their treatment plan: *1). Please describe your treatment plan; 2). Would you consider your treatment plan successful in treating your depression?; 3). If you could*

create your own treatment plan, what would your treatment plan include?; 4). Are you currently taking medication to treat your depression? Why or why not?; and *5). What kinds of activities help to reduce your symptoms of depression?* To the prompts, the most discussed treatment type was experiences and perceptions of medication (187).

Usage and Perceptions of Medication/SSRIs

One woman explained how medication has enhanced her quality of life noting reduction in her depressive symptoms. She shared,

> I am able to live with depression because I am on medication. When I go without my med I feel gloomy and I cried for know reason. I would stay in my bed for hours and stare at the ceiling or wall.

Another woman said, "Yes, i am still on medication to treat my depression. I do not have any side effects from taking my medication. I think that it does help. It keeps me calm and not be so agile." While another woman explained that she uses medication "because it's more useful to [her] than therapy." On the other hand, another participant shared, "Pills more pills I was offered counseling at one point but I'm not comfortable telling anyone about my life."

Participants who responded "no" to, *Have you been or are you currently being treated for your depression diagnosis?* were prompted with the following question, *What are some reasons why you are not being treated for your depression?* One participant shared their past struggles with medication. She explained,

> I used to exercise until I took anti-depressants, and it made me tired during the day and stopped me from sleeping at night. Now I feel worse and have no reference for what would help.

Another participant described the perceived side effects of taking medication and the cycle of treatment. She said, “I refuse to be made suicidal/depressed in order to help with depression that may or may not exist and then switch to another and another and another.” While one participant reflected on her battle after taking SSRIs for her depression. She said, “When I was first diagnosed, my doctor prescribed Zoloft for me. I dealt was memory loss, lack of sleep, and appetite. I couldn’t keep focused on anything.” Others described use of alternative medicine in lieu of traditional prescriptions to treat their depressive symptoms, primarily the use of cannabis. One respondent shared that her treatment plan includes “a relationship with a higher power…therapy and occasionally smoking marijuana.”

Therapy/Counseling

When asked, *what type of provider do you primarily see to treat your depression?* 42 percent of participants identified a mental health clinician, 33 percent as primary care physician, 15 percent did not currently seek treatment, seven percent said other, and three percent identified clergy (see *Figure 5*).

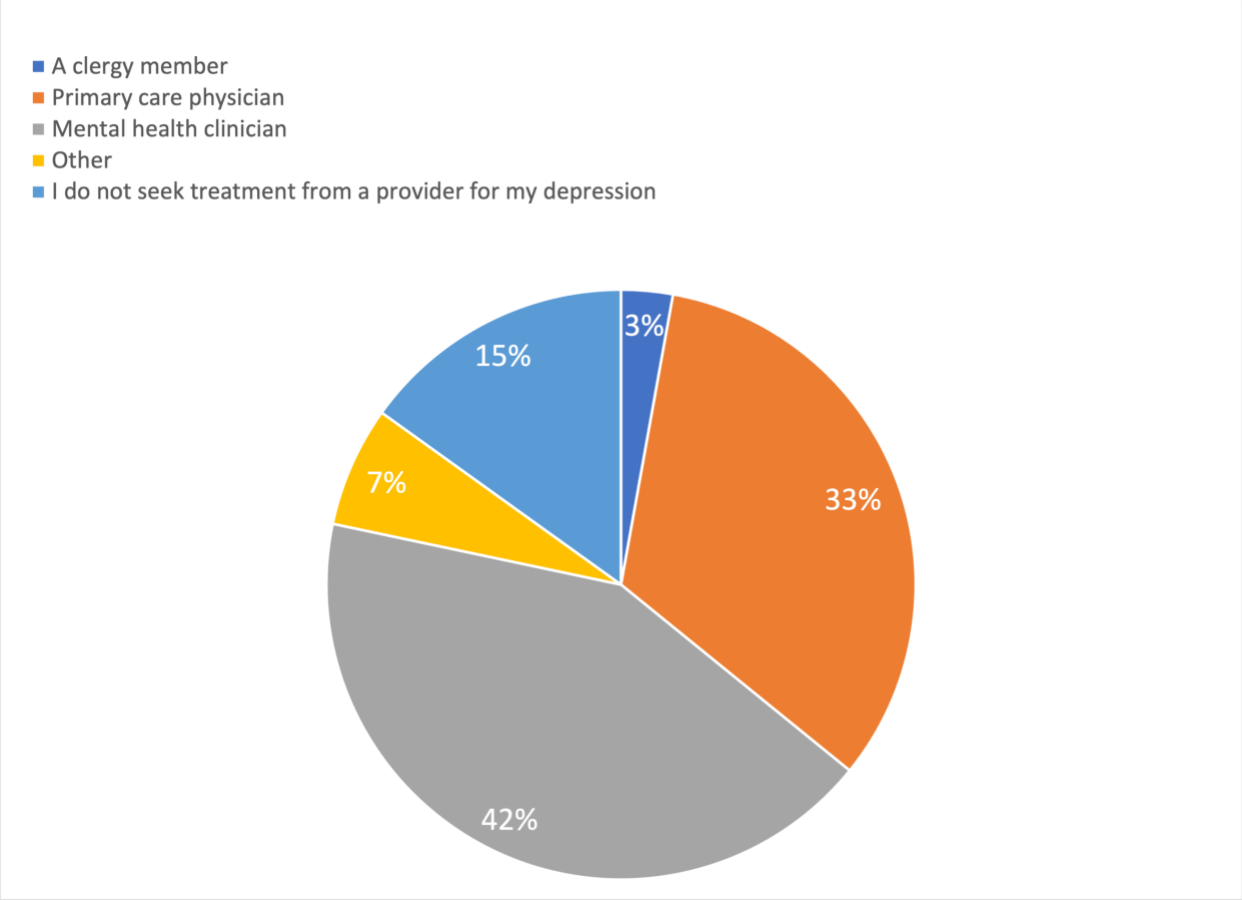

Figure 5 Pie Chart of Provider Preference: Pie chart depicting the type of provider primarily seen to treat depression

Respondents described positive experiences participating in therapy/counseling services (157). Subthemes include discussions of symptom reduction and successful treatment plans (124). One participant described a positive experience with her local Medicaid-based facility. She shared,

> I was offered help for my depression through a Medicaid-based facility in the city I live in. I did and still do use their services because I have been a client for about 3 years, and I am treated with respect when I walk through the door. Mrs. Burns [pseudonym] is very perceptive and intelligent, and she is easygoing. Her personality has helped the improvement of my depression overall.

Another woman talked about her treatment plan, saying, “We are working on me doing less worrying and crying. Trying to talk about positive things and not accepting negative thoughts.” Another participant added, “They make me feel important in the world.” Others described the combination of tools that lead to success,

> Since starting therapy, I dont have as many suicidal thoughts. My health has improved and I now use exercise and diet to feel better about my life. I also use mediation when I feel my Depression might be getting the best of me.

Another shared,

> Well, lets start off with morning meds, I take them every morning. Then I prepare myself to go to my program. I deal with a counselor, and there are other people in the group. I see a psychiatrist every 8 weeks. Put it all together and it works. Yes. I haven't experienced any depression in a while.

Participants also share how therapy help work through past traumas, one woman said, “While working with my therapist, there were traumatic things that happened to me in my

childhood that was deep in my subconscious that was never dealt with." Participants also described how therapy is empowering. One woman said,

> I was given medicine by my doctor but I don't take it because of the side effects. Therapy has been more of a help because I get advice on how to conquer depressive thoughts and solve problems in life through setting goals.

When discussing perceptions of successful treatment plans, one woman shared a list of tools, "counseling sessions, keeping a log of my moods when things happen. tracking my diet and exercise habits, support group and doctor's appointments." Another woman added, "my treatment plan is for me to continue to improve myself and not be stressful about anything. and to continue to take me medicine attend therapy sessions and do not miss my appointments." Participants also discussed the importance of participating in hobbies and activities. One woman said,

> Yes, I would consider my treatment plan successful in treating depression. I have become involved in additional activities, and I are learned coping skills that have reduced my feelings of depression.

Coping Mechanisms

Participants described coping mechanisms useful in managing their depressive symptoms (109). Subthemes that fall into this category are: hobbies and activities (79), faith and prayer (34), and socializing (31). The top activity was exercise (31) concerning "yoga" and "walking or some form of exercise. Getting out of the house." The second top activities were prayer (24) and forms of relaxation or connection with nature (24). See *Figure 4* for a complete breakdown of preferred coping tools. Participants described needing an opportunity for "slowing down [their]

thoughts, thinking more reasonably and constant prayer," as well as "getting involved in outdoor activities and being around people."

Participants described other activities that promote laughter or occupy the time. One woman said she likes "watching movies or listening to music helps tremendously because it occupies my mind. Also, reading & playing video games help." Others referenced art and other creative outlets like "Drawing, painting, journaling, being productive, exercising, and voicing what I'm dealing with and not keeping it to myself." Another participant shared,

> I do all kinds of crafts and art; I sing and dance. I play video games when I'm not working. I keep busy doing something. I haven't been depressed before, only recently, and I don't let it get me down because I'm very religious also; I pray to our Lord Jesus Christ for wisdom and knowledge to get through things in life, and I'm going to start meditating as well, it's very relaxing.

Other participants place similar value on the act and purpose of prayer; one woman described once having "Stress thoughts of killing [herself], but [she] Prayed [her] way through so [she] can have stronger Faith." Another woman shared that she goes to "Christ because you can pray about what you feel without being criticized, embarrassed, or ashamed."

Participants also placed emphasis on socializing. One participant described her life since retiring as, "participating in more social activities and focusing on [herself]/ health have reduced [her] depression." Another woman described "doing fun things with family and friends. Like trampoline parks, water parks. things to take my mind off the fact i was sad. to make me happy."

Table 6. Description and Frequency of Treatment and Subthemes

(n=106)

Theme		Description	Example Quote	Frequency of Excerpts
Treatment	*Medication*	experiences with prescriptions to decrease depression symptoms	[Medication] helps me stay focused and get through the day. Also control my panic attacks.	187
	Therapy/Counseling	describes positive and helpful experiences while participating in therapy/counseling services	My therapist listens to me and it really does help…i use to feel so depress that i did not know what to do i wanted to kill myself but not any more i still have my moments but the feeling is not strong anymore	134
	Coping mechanisms	includes descriptions of useful coping mechanisms under the umbrella of faith and prayer, hobbies, and socializing	I exercise at least 3 times a week by walking for about 30 minutes or 1 hour. I do a lot of arts and crafts, such as making jewelry and doing paper crafts as well.	109
	Barriers to treatment	Includes descriptions of issues accessing mental health services with and without insurance	The last doctor I saw was a Psychologist. He helped the most; but the state, in which I lived at	62

			he time, refused to pay him.	

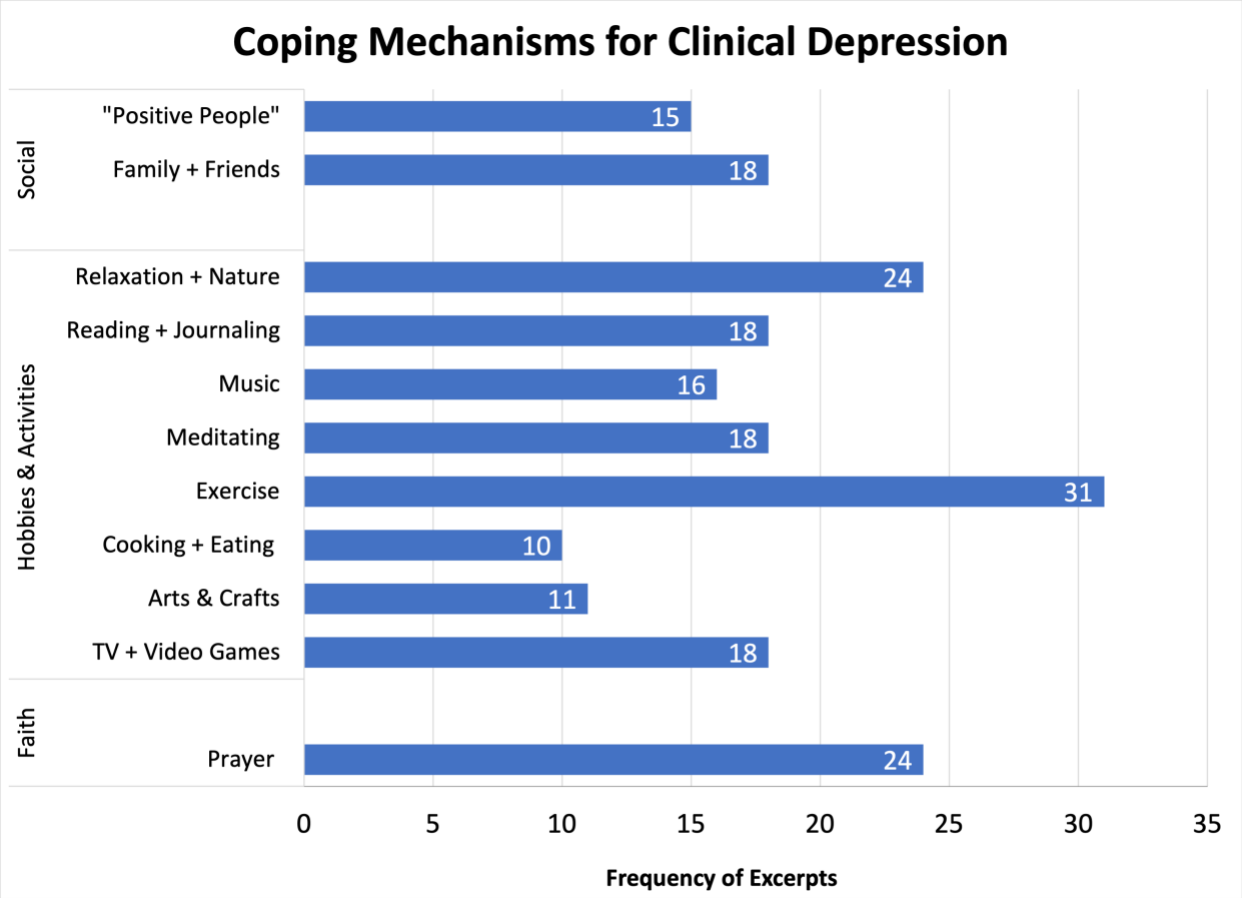

Figure 4. **Coping Mechanisms for Clinical Depression:** A bar graph depicting the most utilized coping mechanisms by Black Christian women with clinical depression: socializing (top); hobbies and activities (middle); prayer (bottom).

Barriers to Treatment

Participants were asked, *have you encountered any challenges getting help for your depression?* The top theme describing barriers to treatment was classified as issues of insurance

and access to resources (62). This theme includes of issues of consistency, lack of time, distance from resources, and expense of mental health care. One participant shared her obstacles to having depression without insurance,

> I've been dealing with depression for over 20 years now. I became severely depressed after my mom died from breast cancer. It's hard because I don't have health insurance to get help. So, I have to deal with it as best as I can. I have a complete lack of energy. I'm not interested in any of the things that I love to do. I'm always feeling hopeless & worthless.

Another participant shared her skepticism of the mental health care system and whether or not she would be correctly diagnosed/treated. She said,

> I was skeptical and remain so. I am not sure if I was correctly diagnosed and have no hope of it ever happening. I cannot imagine what it is like for someone who cannot ask the right questions or be persistent in assuring they are cared for. Even I have given up on trying to get some answers.

Others shared this sentiment as they search for providers. One woman shared the difficulty in "finding a doctor that cares & is willing to do whatever it takes to find a medication that works." Another woman shared the delays in treatment while seeking therapy. She said,

> One therapist had me waiting in the waiting area for 45 minutes even though I had checked in at the front desk and was told to have a seat and the therapist would be calling me and she never did, then when I did see her she not apologetic at all and made me feel like a less than person and my time was not valuable.

Participants also described the expense of healthcare juxtaposed to the process of treatment and seeing results. One woman said, "it hasn't been effective enough in the past, and

it's too expensive to keep experimenting right now." Another woman shared, "money didn't allow me to get treatment beyond diagnosis."

CHAPTER 6: DISCUSSION & CONCLUSION

The purpose of this study is to explore the lived experiences of Black Christian women diagnosed with depression. This study is guided by the following question: *What are the lived experiences of Black Christian women diagnosed with clinical depression?* To answer this question, a qualitative secondary dataset of Black Christian women's responses (n=106), was collected from June 5, 2019, to October 30, 2019. Responses are read to gain clarity on the whole picture, themes and patterns are identified, and subthemes are grouped to reveal relationships within codes and patterns. Descriptive statistics are used to summarize and contextualize experiences and perceptions of depression. Participants reflected on their lived experience within four categories: experiences living with depression; perception of community responses; help-seeking behavior; and treatment. All in all, this study provides an exploratory look into the experiences of Black Christian women with clinical depression, and a closer look into Black women's experiences of depression, its impact on their quality of life, barriers to treatment, and the role of the church, as a result of Black women's connection to the religious and spiritual sustenance (i.e., prayer, relationship with a higher power).

EXPERIENCES OF CLINICAL DEPRESSION

Analogous to studies on depressive symptoms among Black women (Erving et al. 2022, Jones et al. 2022), findings from the present study show that Black women experience the following symptoms related to depression: sadness and loss of interest; feelings of worthlessness and hopelessness; and impairment. Results highlight a discussion for further investigation concerning impairment and chronicity of disease among Black women. Results also found

feelings of dread and shame salient themes related to symptoms of depression. However, this study begets further inquiry into the connection between mental illness and shame through the lens of religious, moral, and ethical standards based on the cross-section of one's gender and adherence to biblical-based gender-norms. Lastly, findings speak to the increased suicide rates among Black Americans by 30 percent between 2014 and 2019 (Ramchand, Gordon and Pearson 2021). Spates (2014) lays the groundwork for exploration into suicide among Black Christian women with her qualitative exploration of resilience and the racial-suicide paradox. Further investigation into the nuances of Black Christian life (religious and spiritual), suicide acceptability, and the intersections of gendered-racist stressors is needed to understand the current increased rates of suicide among Black girls and women is needed (Anglin, Gabriel and Kaslow 2005, Early and Akers 1993). But most importantly, improved intervention methods for institutions like the Black church need to be developed, because most Black women continue to reach back to the chuch as an emotional and mental health resource (Adedoyin and Salter 2013).

SHARING V. PRIVACY

Findings demonstrate that the community for Black women in this context is defined as persons they have deemed trustworthy to share one's intimate struggles with depression with. Although efforts to share in Black women's inner circles are helpful to begin dispelling the stigma around depression, the number of persons one is willing to share with is still too few to not perpetuate a cycle of silence. Moreover, this form of silence propagates a binary of those who "know" and those who "don't know" about the illness. This silence thus impacts social discussions and acceptance of the disease and possible opportunities for greater support within frequented social groups (Abrams, Hill and Maxwell 2019). Abrams et al (2019) discuss the SBW schema and its impact on Black women, referenced as a form of self-silencing that inhibits

communication of depressive symptoms, subsequently impacting their ability to seek out help. On the other hand, though findings in this study show use of *pride* and *strength* to describe attitudes towards one's depression diagnosis, Black women in this study also share the details of their clinical depression diagnoses and seek out help. This coincides with Black women's experience with mental illness and complicated positionality toward sharing and silence, particularly in communities of faith (Coleman 2022, Philyaw 2022). Research should continue to explore the evolution of the SBW schema and its impact over time as awareness of vulnerability and resources for depression become a norm within the Black community, specifically within subgroups of Black Christian women.

PERCEPTION OF BLACK COMMUNITY RESPONSES

Another salient theme was in reference to "Black people don't get depressed," a sentiment that perpetuates depression as a taboo narrative among the Black community. Black women spoke about not wanting to be perceived as weak or more worthless than they already felt. Previous literature speaks to the impact of myths that purport strength over and against Black women's experiences (Carter and Rossi 2019, Green 2019, Harris-Perry 2011). Results in this study reflect the ever-present and unique barriers facing Black women but also the community as it relates to understanding and acceptance of depression and mental illness overall. However, it should be noted that support is the most salient theme and it is promising that some Black women are getting the support they request.

The results show that community perceptions of mental illness include references to belief in God and prayer to seek healing, guidance, and connection. However, there remains a rift between what is seen as an acceptable form of treatment for depression among Black Christian women and medical norms. Western medicine's treatment of clinical depression opposes the

Christian belief that God heals. Nevertheless, the Black church is responsible for responding to the crisis of its congregants. But to address the mental health crisis in a manner that respects Black women's need for mental health care and spiritual sustenance, it will have to address its role in contributing to the unique stressors of Black women. Over the last several decades, Black womanist theologians have exposed the spiritual injustices disproportionately affecting Black women in the Black church (Benbow 2022, Mitchem 2014, Pierce 2013, Williams 1986). Gilkes (2001), in her book, *If it Wasn't for the Women: Black Women's Experience and Womanist Culture in Church and Community*, uses a womanist sociological lens to investigate the intersections of race, class, and gender through the experiences of Black women in the church, particularly their roles and impact on Black life and culture, as well as the internal conflict. This study helps to build on this overview of Black religious life with a focus on the mental health crises among Black Christian women, which is particularly important because of its unique formation and relationship to Black women: socially, politically, mentally, and spiritually.

Based on the findings from this project, religious organizations are well positioned to mitigate the impact of depressive symptoms among members. For example, results point to successful coping mechanisms that promote wellness, physical movement, meditation/breathing, one-on-one and group support. However, program development, for example, places Black women in a quandary because they are often responsible for the bulk of the planning and labor within these organizations (Higginbotham 1993). So, to make efforts to enhance Black religious organizations, we must consider who is responsible and how they are being supported in that space.

Moreover, participants identify clergy as being the main people providing spiritual advice, but only four percent are utilized for mental health care counseling. This points to a gap

in the community, asking what collaborative efforts are possible among mental health clinicians and Black clergy and how these associations could impact the quality of life for Black Christian women living with clinical depression. Additionally, these results begin the discussion of belief in mental illness; instead of viewing responses as a binary—yes or no—participants point to the complexity of *yes, because* or *yes, and.* Results point to the continued tension between ideologies of the *secular* world and the *spiritual* realm.

HELP-SEEKING BEHAVIOR

The two most salient themes among motivations for Black Christian women to seek help were seeking a sounding board and the desire to regain control of one's life. These motivations, in combination with some participants' reflections on the impact of adverse childhood traumatic experiences (ACES), lead one to ask more questions about how to create more spaces that Black Christian women feel they can fully show up and be seen and heard within. Moreover, spaces that provide the opportunity to work through past traumatic experiences. This impact can range from the individual to generations afterward. As previous literature speaks to the impact of intergenerational trauma and the development of depressive symptoms (Lehrner and Yehuda 2018, Stenson et al. 2021), it remains another area for further investigation as it relates to the prevalence and chronicity of the illness, as well as longitudinal impact.

TREATMENT

Findings are similar to previous literature that discusses coping mechanisms specific to Black women's *healing* and reduction of depression symptoms (Mattis 2002, Mossakowski 2003, Park et al. 2018, Spates et al. 2020, Thomas, Witherspoon and Speight 2008, Wise et al. 2006). However, as previously stated, results do point to a gap in educators' knowledge, awareness, and training and resources of affordable care.

The data also shows a complicated relationship between Black women and the utilization of the church for social support. Though they attend church and privately pray about their depression, it remains unclear if Black women intentionally withhold their diagnosis from their religious organization. If so, why, and how does the church address the web of mental illness, spirituality, and vulnerability? Most importantly, how will the church be supported in these endeavors?

Concerning the usage of medication/SSRIs, findings show that they help reduce Black women's symptoms. However, there appears to be a new discussion of alternative medicines, including the use of oils and cannabis. Both are avenues for further exploration, especially as it pertains to self-medication of a stigmatized mental illness that preemptively exposes you to feelings of hopelessness, worthlessness, and shame. In other words, it is imperative to further investigate the impact of self-medication with substances like cannabis—a stimulant and depressant—on the severity of the illness. Barriers to treatment can also speak to alternative medicines/drugs; issues with access to dependable resources, insurance, and expense continue to be pervasive issues for Black women. In the book, *I Bring the Voices of My People: A Womanist Vision for Racial Reconciliation*, Chanequa Walker-Barnes (2019) draws on critical race theory and intersectionality to argue that the unique stressors facing Black women are rooted in systems of power and inequity upheld at the intersections of the Black woman's existence. She goes on to say that Black women have the power to dismantle systems of domination.

ADDRESSING LIMITATIONS

As in any study, limitations should be considered and addressed. Firstly, secondary qualitative datasets can be difficult to manage and/or interpret due to differences in the primary study's objectives and aims. However, this should not be an issue due to the similarities between

this study's research question and the primary study's aim. Secondly, the shorter length of the open-ended responses from participants can make analysis more challenging and impact overall reliability. Although this issue is often found in qualitative research, Silverman (2021) provides methods to mitigate and enhance reliability like refutantional analysis and constant data comparison, which were also implemented in this study. Third, as mentioned previously, the validity of the dataset was an advantage for this study because of the sample and complementary methodology and analysis. Additionally, data triangulation was possible using the qualitative and quantitative data enhancing validity of the study as well. Contemporary frameworks of validity emphasize and support the notion that validity is not the property of the measurement instrument alone but the "interpretation of the resulting measurements or scores from an instrument's use within a specific group and for a particular purpose" (Peeters and Harpe 2020). Thus, by utilizing both open and close ended questions and theoretical triangulation (BFWT, Womanist Theology and Intersectionality) helped to contextualize the responses and mitigate issues of reliability. Lastly, although generalizability is not the goal, there are pragmatic approaches to assess criteria for validity, specifically, systematic sampling, triangulation and data comparison, documentation, and multi-dimensional theory (Leung 2013).

THEORETICAL IMPLICATIONS

Historical and contemporary challenges that disproportionately impact Black Americans (i.e., access to resources and information, stigma, and discrimination, etc.) have thwarted our understanding of depression among Black people. Scholarship lacks nuance on the convergence of the Black religious experience and mental illness. Thus, impacting its ability to address the quality of response to the mental health crisis for Black Americans. Furthermore, a gap remains in the literature on the Black religious experience and the question of what turns a protective

factor into a risk factor, and how much does it impact one's mental health? The Black religious life has historically been categorized as racially autonomous, Christian, and a progressive space for the refugee. This overgeneralization has upheld research on the protective factors of religion and spirituality and thus overshadowed investigation on the complexity of not only Black religious life but, in the case of this study, Black Christian religious life, for Black women in particular. Thus, we are left with an incomplete understanding of Black people's mental health perceptions and experiences, and this study illuminates the relationship between Black Christian women with depression and their relationship with their religious community and faith.

From the womanist perspective, this study contributes theoretically to BFWT by centering Black women's voices through their experiences and definitions related to their mental illness. Moreover, by examining the intersection of their race and gender within the context of Christianity, a current overview of the experiences of Black Christian women living with clinical depression is provided. This work speaks to Black women's experience to enhance survival and end all forms of oppression that work over and against Black women. Through the work of intersectionality, the conversation is pushed forward about the intersecting systems of power afflicting Black Christian women, particularly those living with clinical depression. This study explores the experiences of those at the intersection of race (Black), gender (Woman), religion (Christian), and disability (Mental illness/ clinical depression), exposing the multiplicity of systems of power that can inhibit Black Christian women's access to holistic care (e.g., self-silencing, lack of religious community support).

This study helps to illuminate the gaps in our understanding of the Black-white paradox in mental health as it relates to the role of religion and spirituality. Black Christian women have historically had a complicated relationship with the church, but their connection to God is

unwavering (Cannon 1995). This complexity needs to be extrapolated so Black Christian women with clinical depression can get the support needed. Audre Lorde (1988), a Black, lesbian, mother, warrior, and poet in, *A Burst of Light,* states, "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare." Lorde brings to light the tension Black women face between self-care and caring for others; a cry for radical self-love. To participate in self-care as a Black Christian woman is arguably antithetical when juxtaposed to racist-gendered cultural norms that exist in both biblical hermeneutics and social Christian spaces.

To go against the grain and care for oneself is an act of social justice. Part 3 of the definition of womanism is "Loves music. Loves dance. Loves the moon. Loves the Spirit. Loves love and food and roundness. Loves struggle. Loves the Folk. Loves herself. Regardless." Using Walker's (1983) definition of womanism and call for radical love of self and culture, Lorde's appeal to self-care in the name of justice, and (Townes 2006) the womanist ethic of care and call for spiritual justice, we are challenged us to ask, for Black Christian women, is *caring for oneself an act of spiritual warfare?* If so, how do we address the unique medical and spiritual needs of Black Christian women living with clinical depression? What social systems intersect, perpetuating systems of power and domination against Black Christian women specifically?

This study offers a much-needed contribution to disciplines beyond sociology. Specifically, work published in psychology, gender studies, religious studies, and public health expands and helps guide these conversations, and this study can contribute to these conversations.

FUTURE RESEARCH

Sociologists note the protective factors of religiosity and spirituality, but there is a lack of nuance concerning the impact of one's belief system on their mental health (Powell, Shahabi and Thoresen 2003). For instance, the perspective that mental illness is the "voice of the devil" remains prevalent in the Christian church and religious circles today. Consequently, individuals tend to see personal devotion or prayer to a higher power as the primary and often only treatment solution. Black women are the most religious group in the U.S., but Black Americans report increased rates of chronic depression followed by decreased treatment rates. Further research is needed to understand access to resources (i.e., consistent in/outpatient therapy, prescriptions) through the intersecting systems of race, gender, parental status, and socioeconomic status. In addition, continued research in mental health focusing on Black Christians will inform our understanding of help-seeking behavior, treatment plans, and action to destigmatize mental illness intra- and inter-communally. Lastly, because this study underscores the intersection of religion, race, and gender, it will continue to contribute to the field's understanding of culturally relevant practices and interventions.

CONCLUSION

This project seeks to continue the theoretical works of Black Feminist Theory, Womanism, Womanist Theology, and Intersectionality in the following ways: 1). empower Black women's knowledge production; 2). center Black women's experiences; 3). advocate for social and spiritual justice (i.e., critique of the Black church), 4). provide a critique and solutions of and for the Black church and 5). this study demonstrates how intersecting systems of power can and will disproportionately impact vulnerable groups, like Black Christian women with clinical depression. Merging theology with our understanding of social agents fosters greater

insight into systems of oppression and tools to mitigate the negative impact to one's psyche. Although the prevalence of depression is similar between Black and White communities, suicide rates have increased over time among Black Americans and clinical depression persists for longer amongst Black Americans. This is an emerging mental health crisis. Symptoms of depression manifest differently in Black people, and they are less likely to pursue treatment or be able to remain getting services. Therefore, it is imprudent to find treatment plans sensitive to the intersectional experiences of those living with major depressive disorder, like Black Christians.

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A. Survey Questions

African Americans and Depression_6-5-19

Start of Block: Informed Consent

Q58 **African Americans and Depression**

You are being invited to participate in a research project entitled, “A Qualitative Exploration of African American’s and Depression,” which is being conducted at Kent State University under the direction of Dr Kamesha Spates and Dr. Na’Tasha Evans. The purpose of the proposed research is to investigate the experiences of African Americans that have been diagnosed with clinical depression.

This consent form will provide you with information on the research project, what you will

need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you understand the research in order to make an informed decision about participation. Before you take part of the survey, please read the consent form below. Please click on the "I agree" bottom at the bottom of the page if you understand the statements and freely consent to join the survey.

Consent Form The purpose of the proposed research is to investigate the experiences of African Americans that have been diagnosed with clinical depression. We would like to invite you to complete an online survey. The survey will take about approximately 15 minutes. You will be asked questions about your experiences living with depression. Your participation is anonymous, and in no case will responses from individual participants will be identified. This research will not benefit you directly. However, your participation in this study will help us to better understand how to provide better services to African Americans dealing with depression. There are no anticipated risks beyond those encountered in everyday life. Participation in the study is voluntary; refusal to take part in the survey involve no penalty. You can choose not to answer any question that makes you uncomfortable or stop the survey at any time without penalty. Taking part in this research study is entirely up to you. You may choose not to participate, or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled.

If you have any questions or concerns about this research, you may contact Dr. Kamesha Spates at 330-672-0314 or kspates1@kent.edu. You can also contact Dr. Na'Tasha Evans at (330)-672-1454 or nevans8@kent.edu. This project has been approved by the Kent State

University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330.672.2704.

Q57 I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I understand my participation in the study is voluntary and I can withdraw anytime.

- ○ I agree (1)
- ○ I disagree (2)

Skip To: End of Block If I have read this consent form and have had the opportunity to have my questions answered to my sa... != I agree

Page Break

quality

We care about the quality of our survey data and hope to receive the most accurate measures of your opinions, so it is important to us that you thoughtfully provide your best answer to each question in the survey.

Do you commit to providing thoughtful and honest answers to the questions in this survey?

- ○ I will provide my best answers (1)
- ○ I will not provide my best answers (4)
- ○ I can't promise either way (5)

Skip To: End of Block If We care about the quality of our survey data and hope to receive the most accurate measures of yo... != I will provide my best answers

End of Block: Informed Consent

Start of Block: Eligibility

Q55 Are you at least 18 years of age?

- ○ Yes (1)
- ○ No (2)

Skip To: End of Block If Are you at least 18 years of age? = No

Q9.2 What is your race? (Please check all that apply)

- ☐ African American (1)
- ☐ White (2)
- ☐ American Indian/Alaska Native (3)
- ☐ Asian (4)
- ☐ Native Hawaiian/Other Pacific Islander (5)
- ☐ Other (6) _____

Skip To: End of Block If What is your race? (Please check all that apply) != African American

Q56 Have you ever been diagnosed with clinical depression by a medical professional?

- ○ Yes (1)
- ○ No (2)

Skip To: End of Block If Have you ever been diagnosed with clinical depression by a medical professional? != Yes

End of Block: Eligibility

Start of Block: Sources of information about depression

Q62 In this section, we are interested in **learning more about the information you received about depression throughout your life from people other than your provider.**

*

Q1.1 Throughout your life, where did you receive most of your information about depression?

_____

_____

_____

_____

_____

*

Q1.2 Throughout your life, what type of information did you receive?

_____

_____

_____

_____

_____

*

Q1.3 Throughout your life, what were your thoughts about the information that you received?

_____

_____

_____

_____

_____

End of Block: Sources of information about depression

Start of Block: Experiences living with depression within the Black Community

Q61 In this section, we are interested in your experiences **living with depression**.

*

Q2.1 Can you describe your experiences living with depression?

_____

_____

_____

_____

_____

Q2.2 Have you shared information regarding your depression diagnosis with anyone?

- Yes (1)
- No (2)

Q2.3 If so, who?

_____

_____

_____

_____

_____

Q2.4 Is there anyone that you have intentionally not told about your diagnosis? Why?

_____

_____

_____

_____

_____

Q2.5 How did others' respond to finding out about your depression diagnosis?

_____

_____

_____

_____

_____

Q2.6 What advice have you received from your friends, family, or community members regarding how to deal with your depression diagnosis?

_____

_____

_____

_____

_____

End of Block: Experiences living with depression within the Black Community

Start of Block: Perceived Discrimination about depression within the Black Community

Q60 In this section, we are interested in your experiences with **discrimination and depression**.

Q3.1 Do you think that there are differences in how Blacks and Whites who are diagnosed with depression are treated by medical providers?

- Yes (1)
- No (2)

Display This Question:

If Do you think that there are differences in how Blacks and Whites who are diagnosed with depressio... = Yes

Q3.2 If so, please describe.

_____

_____

_____

_____

_____

Page Break

Q3.3 Do you think that there are differences in how Blacks and Whites who are diagnosed with depression are portrayed in the media?

- ○ Yes (1)
- ○ No (2)

Display This Question:

If Do you think that there are differences in how Blacks and Whites who are diagnosed with depressio... = Yes

Q3.4 If so, please describe.

_____

_____

_____

_____

_____

End of Block: Perceived Discrimination about depression within the Black Community

Start of Block: Perceptions of depression

Q59 In this section, we are interested **how you view depression**.

Q4.1 What were your personal thoughts about being diagnosed with depression?

_____

_____

_____

_____

_____

Q4.2 What have been the most common perceptions shared with you from other Black people about Black people who are diagnosed with depression?

_____

_____

_____

_____

_____

End of Block: Perceptions of depression

Start of Block: Perceptions of mental health therapy

Q63 In this section, we are interested in **how you view mental health therapy**.

Q5.1 What do you think about counseling or mental health therapy?

_____

_____

_____

_____

_____

Q5.2 Do you feel judged, criticized or ostracized for being depressed or seeking treatment? Why or why not?

_____

_____

_____

_____

_____

End of Block: Perceptions of mental health therapy

Start of Block: attention_check

attention

To show you are paying attention please select "Somewhat agree" below:

- ○ Agree (1)
- ○ Somewhat agree (4)
- ○ Neither agree nor disagree (5)
- ○ Somewhat disagree (6)
- ○ Disagree (7)

Skip To: End of Block If To show you are paying attention please select "Somewhat agree" below: != Somewhat agree

End of Block: attention_check

Start of Block: Treatment

Q64 In this section, we are interested in **your personal experiences surrounding your treatment plan for depression**.

Q6.1 Have you been or are you currently being treated for your depression diagnosis?

- Yes (1)
- No (2)

Q9.15 What type of provider do you primarily see to treat your depression?

- A clergy member (1)
- Primary care physician (2)
- Mental health clinician (3)
- Other (4) _____
- I do not seek treatment from a provider for my depression (5)

Display This Question:

If Have you been or are you currently being treated for your depression diagnosis? = Yes

Q6.2 Please describe your treatment plan.

_____

_____

_____

_____

_____

Display This Question:

If Have you been or are you currently being treated for your depression diagnosis? = Yes

Q6.3 Would you consider your treatment plan successful in treating your depression?

_____

_____

_____

_____

_____

Display This Question:

If Have you been or are you currently being treated for your depression diagnosis? = Yes

Q6.4 If you could create your own treatment plan, what would your treatment plan include?

_____

_____

_____

_____

_____

Display This Question:

If Have you been or are you currently being treated for your depression diagnosis? = No

Q6.5 What are some reasons why you are not being treated for your depression?

_____

_____

_____

_____

_____

Page Break

Q65 In this section, we are interested in **your personal experiences surrounding your treatment plan for depression**.

*

Q6.7 Are you currently taking medication to treat your depression? Why or why not?

_____

_____

_____

_____

_____

Page Break

Q67 In this section, we are interested in **your personal experiences surrounding your treatment plan for depression**.

*

Q7.3 What kinds of activities help to reduce your symptoms of depression?

_____

_____

_____

_____

_____

End of Block: Treatment

Start of Block: Help seeking behaviors

Q66 In this section, we are interested in the **types of professional help you've received to help you deal with your depression**.

*

Q7.1 What services were recommended to you from health care professionals to help treat your depression?

_____

Q7.2 Did you use those services? Why or why not?

_____

Q7.4 Do you feel that seeing your counselor or therapist has has helped to improve your symptoms of depression?

- Yes (1)
- No (2)
- I do not see a counselor or therapist (3)

Q7.5 Why or why not?

_____

_____

_____

_____

_____

Q7.6 What are your top three reasons for seeing a counselor or therapist?

_____

_____

_____

_____

_____

Q7.7 Have you encountered any challenges getting help for your depression?

_____

_____

_____

_____

_____

End of Block: Help seeking behaviors

Start of Block: Religion and spirituality

Q69 In this section, we are interested in **your experiences with religious or faith-based organizations**.

Q71 Are you a member of a religious or faith-based organization?

- Yes (1)
- No (2)

Skip To: End of Block If Are you a member of a religious or faith-based organization? = No

Page Break

Q72 In this section, we are interested in **your experiences with religious or faith-based organizations**.

Q8.1 If you are a member or religious organization, do the leaders and or members of your organization believe in mental health diagnoses and treatment? Why or why not?

_____

_____

_____

_____

_____

Q8.2 If you are a member or religious organization, do you feel supported by the members of your organization? Why or why not?

_____

_____

_____

_____

_____

Q8.3 Has a member of your religious organization ever told you to use prayer as a means to deal with your depression? If yes, by whom?

- ○ Yes (4)
- ○ No (5)
- ○ Prefer not to answer (6)

Display This Question:

If Has a member of your religious organization ever told you to use prayer as a means to deal with y... = Yes

Q70 If yes, by whom? What was your experience?

_____

_____

_____

_____

_____

End of Block: Religion and spirituality

Start of Block: Demographic questions

Q9.1 Do you identify as Hispanic, Latina, or of Spanish origin?

- Yes (1)
- No (2)

Q9.3 What is your gender?

- Male (1)
- Female (2)

Q9.4 Do you consider yourself to be:

- Heterosexual (straight) (1)
- Gay or lesbian (2)
- Bisexual (3)
- Other (4) _____

Q9.5 In what year were you born?

_____

Q9.6 In which state do you live in?

▼ Alabama (1) ... I do not reside in the United States (53)

Q9.7 How would you describe your current relationship status?

- Single (1)
- Single but living with partner (2)
- Married (3)
- Legally separated (4)
- Divorced (5)
- Widowed (6)

Q9.8 What is your highest level of education completed?

- ○ Graduated High School/GED (1)
- ○ Associate Degree (2)
- ○ Bachelor's Degree (3)
- ○ Master's Degree (4)
- ○ Doctoral/Professional Degree (5)
- ○ Did not complete High School/GED (6)

Q9.9 What is your annual household income?

- ○ Less than $10,000 (1)
- ○ $10,000 to less than $15,000 (2)
- ○ $15,000 to less than $20,000 (3)
- ○ $20,000 to less than $25,000 (4)
- ○ $25,000 to less than $35,000 (5)
- ○ $35,000 to less than $50,000 (6)
- ○ $50,000 to less than $75,000 (7)
- ○ $75,000 or more (8)

Q9.10 What is your current employment status?

- ○ Employed (1)
- ○ Self-employed (2)
- ○ Out of work for 1 year or more (3)
- ○ Out of work for less than 1 year (4)
- ○ Homemaker (5)
- ○ Student (6)
- ○ Retired (7)
- ○ Unable to work (Please describe) (8)

_____

Q9.11 If you are employed, which best describes your employment status?

- ○ Full-time (1)
- ○ Part-time (2)
- ○ Seasonal (3)

Q9.12 What is your current religion, if any?

- ○ Protestant (1)
- ○ Christian (2)
- ○ Catholic (3)
- ○ Buddhist (4)
- ○ Hindu (5)
- ○ Muslim (6)
- ○ Jewish (7)
- ○ Mormon (8)
- ○ Agnostic (9)
- ○ Atheist (10)
- ○ Other (please specify) (11)

_____

- ○ Don’t Know (12)
- ○ Prefer Not to Answer (13)

Q9.13 I was diagnosed with depression ...

- ○ Within the last year (1)
- ○ 1-2 years ago (2)
- ○ 3-5 years ago (3)
- ○ More than five years ago (4)

Q9.14 Who diagnosed your depression?

- ○ Primary care physician (1)
- ○ Mental health clinician (2)
- ○ Other (3)

Q9.16 What is the race of your primary medical or mental health provider? (Please check all that apply)

- ☐ African American (1)
- ☐ White (2)
- ☐ American Indian/Alaska Native (3)
- ☐ Asian (4)
- ☐ Native Hawaiian/Other Pacific Islander (5)
- ☐ Other (6) _____

Q9.17 Would you prefer that your mental health provider be of the same racial background?

- ○ Yes (1)
- ○ No (2)
- ○ Prefer not to say (3)

Q9.18 What type of insurance do you have?

○ Medicaid/ Medicare/ Governmental Insurance (1)

○ Health insurance (including insurance from your work or your husband's/partner's work) (2)

○ None/ Personal income (cash, check, or credit card) (3)

○ Other (Please describe) (4)

_____

End of Block: Demographic questions

B. Codebook

THEME NAME	DEFINITION	DESCRIPTION	QUALIFICATIONS OR EXCLUSIONS
Barriers To Treatment			
"I Can Handle It Myself"	includes systematic and personal obstacles when seeking treatment	this ranges in participant wanting to handle illness on their own, and or the illness was in the way of participant getting help	"no issues" does not imply that they have had positive experiences, but could have chosen not to share. Look at context and if there are mentions of challenges shared in previous questions
+Experiences Or NA		participant describes positive experiences in healthcare system or states "no issues"	
Family + Friends			only family and friends
Systemic Issues		includes issues/obstacles related to seeking help for diagnosis	includes negative experiences with mental health clinicians, issues of time, and finances
Insurance+Access To Resources			only includes issues related to cost of care
Stigma		disapproval of medicine, therapy, etc.	inlcudes personal stigma toward treatment (e.g., therapy, SSRIs)
Community Responses To Depression	perceptions of community responses about MDD, participant discusses issues related to advice given or lack thereof related to depression diagnosis		
Church + Prayer		suggests one to pray, refer to God or personal faith for help or healing	
Clergy + Members			suggestions from clergy and congregants only
Family + Friends			suggestions from family, friends, co-workers only

Supportive/Helpful		concerned and cares about well-being, connects with diagnosis	
"One-Day-At-A-Time"		includes mentions of positive thinking, take a break, be strrong, etc.	perceptions and suggestions from community only
Treating Illness		includes therapy, counseling, coping skills, and medication	perceptions and suggestions from community only
Unsupportive		describes doubt, surprise/disbelief, distrust of person's feelings and experiences	
Judgement Of Healthcare		community perceptions of the discrimination of black people with depression	includes stereotypes of healthcare system and reasons not to seek help
Dismissive Or Taboo Topic		includes desciptions of Black community not talking about illness and dismissive responsives "don't worry" "nothing" "excuse"	
Judgment Or Pity		mentions of seeking attention	includes reflections of others feeling sorry, or alluding to participant being "crazy"
Experiences With Depression	participants' descriptions of living with depression, includes outlook od diagnosis, and issues/obstacles related to relationships and comorbidity		
ACES/Adult Trauma		describes impact of trauma on depression,and reason for diagnosis	includes other mentions of traumatic experiences in adulthood that influence symptoms and diagnosis
Better Over Time		describes positive experiences, overcoming obstacles, learning about self, etc.	includes mentions of hope
Clarity, Understanding Of Self		describes having greater understanding of themselves and experiences as result of diagnosis	

Impact On Relationships In Denial Or Rejection Of Diagnosis		describes who was impacted by diagnosis other than self	family, friends, partners, work, etc. only
Motivations To Seek Help			
Learn Coping Mechanisms	describes seeking change and tools to create change		includes mentions of seeking help to access medication/SSRIs
Outside Suggestion			
Regain Control/Seeking Change		particpant describes urgency for help to reduce symptoms of depression and enhance their quality of life	
Sounding Board/Trusted Guide		describes importance of being able to trust the medical professional and experience mutual respect to be able to share and be a sounding board - includes mentions of cultural competency and release of emotions;	
Religiosity & Spirituality			
Belief In Mental Illness	role of church (clergy, members, theology) and faith (connection to God) in mental illness		
Yes, But, It Is Spiritual Warfare		perceptions of church's support/understanding of mental health care and role of health care system	includes mentions of praying it away, God is all you need, its demonic
Yes, Because God Appoints People		perceptions of church's lack of support of the health care system, and emphasis on spiritual warfare	includes church's support/understanding of mental health care and role of faith in God
Social Support			
Helpful & Understanding		includes mentions of prayer, reading scripture, confiding in other congregants	
Non-Disclosure		mistrust, privacy	

Sharing Diagnosis			
Disclosure Of Diagnosis		describes selective sharing about diagnosis and purpose participant describes sharing with others to educate, connect, etc.	
Everyone - "Not Hiding It"			
Family Member			includes parent, grandparent, children
Friend			
Health Care Professional			doctors, therapist, counselor, etc.
Spouse/Partner			married, significant other
Nondisclosure Of Diagnosis	sharing v. not sharing, including reasons why or why not	includes people participant chooses not to disclose to and reasons	
Family Member			includes parent, grandparent, children
Friends			
No One			
Spouse/Partner			married, significant other
Strangers/People Outside Familial Circle			
Reasons For Non-Disclosure		describes not sharing diagnosis and purpose	
Fear And Rejection		mentions of fear of judgment, being a burden, or abandoned	
Privacy		describes it as a personal matter, selective sharing with close people only, depth of what's shared varies	
Symptoms Of Depression			
+ Other Health Issues	presentation of depressive symptoms based on participant first-hand experiences	includes mentions of being diagnosed with other illnesses (mental and physical) as a result of having depression	includes anxiety, high blood pressure, etc.
Dread & Shame		expression of feelings of fear, embarrassment, lack of self-worth as result of diagnosis	includes terms like "crazy," self-hate talk

Impairment & Suicide Ideation		describes participant unable to physically move or set goals for the future as result of diagnosis	
Sadness & Loss Of Interest		expression of decreased participation in daily activities, withdrawn, loss of energy, unhappiness, and mood swings as result of diagnosis	
Treatment Type(S)			
Coping Mechanisms			
Church + Prayer		descriptions of utilizing rituals and faith to cope with depression	includes mentions of going to church
Prayer			includes talking to God, or higher power
Hobbies + Activities			
Arts & Crafts	describes treatment plans being utilized or that one desires to use based on their perceptions and/or past experiences		
Cooking + Food			
Exercise			
Meditating		includes deep breathing exercises & positive thinking	
Music			
Reading + Writing		includes mentions of sleep, breaks, taking a drive, nature	
Relaxation + Nature			
TV + Video Games			
Socializing		spending time with loved ones or people in general	
"Positive People"			includes support groups, church family, strangers, etc.
Family + Friends			
Ssris/Drugs		use of prescriptions	
Alternative Medicine			includes mentions of cannabis and oil

No Medicine Or Drugs	stigma about medicine or poor experiences	
Positive Therapy/Counseling Experiences		
Group Therapy	includes support groups, workshops, etc.	
No Therapy	poor experiences and/or perceptions of stigma against therapy	includes mentions of therapy is a "weakness"
Successful Treatment Plan (TP)	positive outliook about personal TP	includes mentions of decreased depressive symptoms
Unsuccessful TP Or Change Needed	TP needs work	includes ideas to make improvements (personal and systematic)