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Mental Illness among African American Women: *Creating Dialogue to Increase Parity*

In 2001 7.5 million African Americans were diagnosed with a mental illness. Statistical data indicates that 60% of African American women exhibit signs of a mental illness. However, only 12% of African American women receive treatment. (Ward, Clark & Heidrich 2010) A summary given by the U.S. Department of Health and Human Services Office of Minority Health in 2010 of African Americans Mental Health provided the following data for women in this racial category: 5.2% had feelings of sadness, 2.8% hopelessness, 2.5% worthlessness and 10.4% felt everything took great effort. (www. http://minorityhealth.hhs.gov) The difference between those exhibiting symptoms or having been diagnosed juxtaposed to those treated is substantial. Most provocative is the correlation between social inequalities and stigma within the community to health disparity among African American women. Along with the physical dynamics of the disease the biopsychosocial elements are equally important to understand. The study of the social and cultural aspects as it relates to lack of treatment is necessary to understanding the disparity; and attention to these issues will lead to individuals seeking treatment.

Those who have researched and written about this topic address only the causation and the startling data, but few address plans of action to lower this disparity. This is why study and dialogue on this matter and populace is essential. One of the most effective forms is deliberative dialogue with the intent to solve problems. This research explores mental illness in this group including issues with the diagnostic process, ramifications of stigma and how effective dialogue can be utilized to create parity among African American women. The increased role of patient advocacy as a link to lowering health disparity. How studies show a willingness on the part of nurses to serve in this capacity. How communicative approaches can be utilized by health care advocates and patients to contribute to the discussions for improvement of policy and parity.

**African American Women and Mental Illness**

Each scholar will provide insight as to the causation and biopsychosocial implications for mental health among African American women. The research will indicate that lack of study for this populace along with social identity and access has contributed to mental health disparity.

Ward, E. C., Clark, L., & Heidrich, S. (2010). African american women's beliefs, coping

behaviors, and barriers to seeking mental health services. *National Institutes of Health, 19*(11), 1589-1601. doi: 10.1177/1049732309350686

*Earlise C. Ward, Le Ondra Clark, and Susan Heidrich University of Wisconsin, Madison, Wisconsin School of Nursing*

Ward, Clark & Heidrich (2010).Factors which position African American women at a higher risk include: lower income, health conditions, stress from multiple commitments, access to healthcare, and absence of support, restricted resources, lack of knowledge and minority status. Stress from discrimination are factors to mental health issues along with marital status, education, and religious background. Internal and external cultural determinants also pose as threats to African American women’s vulnerability in this area. African American women with mental illness are marginalized, many of lower economic status, limited in resources, elderly or under aged. Many are individuals who are faced with poor physical, psychological and social health conditions, and the implications of social stigma of mental illness within this community. These factors have also contributed to African American women being overlooked, understudied and underserved. Lack of consideration has placed African American women in jeopardy specifically in regards to mental illness. Additionally, older women within this populace who suffer from depression oftentimes due to chronic illness have an increased vulnerability.

*Emilie M. Townes St. Paul School of Theology Kansas City, MO Christian School of Ethic & Black Church Ministries*

Townes (1998). Historically, African American women’s health issues have not been of grave concern in the United States. African American women have been stereotyped as being strong in adverse situations, and consequently their needs have continued to be overlooked. In the context of health care alone, this belief has contributed to African American women suffering from various chronic illnesses. It would seem this characterization became a misconception which African American women tried to embody. These external and internal cultural ideals created a self-conceptualization African American have which has prevented acknowledging symptoms of mental illness. The pressure of this social identity has led to this personal adaptation. Poor quality of life and occupations also prohibit them from considering the consequences of ignoring the signs of mental health issues. Unfortunately, these created a pattern in regards to the general health and well-being of African American women in the United States.

Rosen, D., Tolman, R. M., Warner, L. A., & Conner, K. (2007). Racial differences in mental

health service utilization among low-income women. *The Haworth Press*, *23*(2/3), 89-105. Retrieved from <http://swph.haworthpress.com>

*Daniel Rosen, Ph.D. and Kyaien Conner, MSW University of Pittsburgh School of Social Work, Richard M., Tolman, Ph.D. School of Social Work University of Michigan., Lynn A. Warner University of New York at Albany School of Social Welfare.*

Rosen, Tolman, Warner & Conner (2007). Research was conducted of 668 African American women participants with mental illness and low level of health parity. The study also was part of a systematic effort induced to transition these women from government assisted incomes to productively employed individuals. In order for African American women who suffer adverse consequences due to their mental illness to become or return to economically independent productive lives medical and mental issues should be addressed. Medical concerns of African American women with mental illness can no longer be ignored. Disbursement of specialized educational propaganda to properly inform patients of their new health diagnosis is necessary for reduction. Increased diverse educational training for culturally sensitive interventions should be developed to comprehend applicable internal cultural deterrents.

Kaplan, M. S., & Sasser, J. E. (1996). Women behind bars: Trends and policy issues. *Journal of Sociology & Social Welfare*, *23*(4), 43-56.

*Mark Kaplan*, *D.Ph. and Jennifer Sasser Portland State University, College of Urban & Public Affairs: School of Community Health*

Kaplan & Sasser (1996). There is also issue of the period of time it takes for African American to receive a proper diagnosis and the ramifications due to this delay. American women who are incarcerated today are predominately the country’s most vulnerable. They include the poor, uneducated and unskilled--disproportionately among them are African American women. These women fall into the criminal justice system as a result of a misdiagnosis or none at all, little or no access to health care, limited support system, economics and police policy. There is a prevalent need for women with mental illness to receive humane treatment and empathetic care.

All four authors are in agreement and have concern about the issue of health disparity of African American women with mental illness in the United States. Each author provides insight to the causes and effects. Some emphasis was placed on race, class and gender while some focus was given to the external and internal cultural aspect of causes. They suggest cultural sensitivity training, educating patients about mental illness and equity in access to health care as solutions.

**Role of Patient Advocacy in Lowering Health Disparity in African American Women with Mental Illness**

The authors will explore how advocating for patients has developed into an integral part of the care nurses provide. The growing concern also as to how to change policy. Cultural competency and understanding how to treat African American women with mental disorders is important.

Chesnay, M. D., & Anderson, B. A. (2008). *Caring for the vulnerable: Perspectives in nursing theory, practice and research*. (2nd ed.). Sudbury, MA: Jones and Bartlett Publishers.

*Mary de Chesnay College of Nursing at Seattle University Seattle, WA. Heather Anderson Seattle University Seattle, WA*

*Natale-Pereira, Enard, Nevarez & Jones Center for Research on Minority Health, University of Texas MD Anderson Cancer Center, Department of Health Disparities Research,*

Chesnay and Anderson (2008). In the United States the crisis of health disparity is among its’ most vulnerable populations. Vulnerable populations are defined and thought of as helpless, victims, susceptible, at risk or marginalized. Caring for the vulnerable can be as complex as their situations. In 1998 former President Bill Clinton made it an issue to reduce health disparities in the United States by 2010; however, despite his efforts and the Affordable Healthcare Act initiated by President Barack Obama in 2014, the country continues to battle with this crisis. President Bill Clinton and the Department of Health and Human Services focused on six areas of health issues in efforts to reduce disparities. The National Institute of Health devised a plan focusing on three key areas to accomplish a reduction by 2010. They developed a strategic plan to delegate funds to the areas of infrastructure, public information/community outreach and research. (Natale-Pereira, Enard, Nevarez & Jones 2011) Additionally, The Affordable Healthcare Act seeks to lower cost, increase accessibility, and expand coverage of health insurance for under insured individuals, increase medical facilities and coordination of care. With these expansions, the role of patient advocacy is increasing. Advocating for patients has developed into an integral part of the care nurses provide. It is a concept of accountability and more of a moral and ethical principle in regards to nursing. Co-partnerships between medical providers and their patients suggesting they provide health care information, negotiate, seek consensus on management and offer aide for shared decision making are suggested solutions. Implementing these approaches can eliminate negative attitudes towards use of health services.

Chesnay and Anderson (2008). The dynamics of society, relationships, community and individuals are all determinants of vulnerability. There is a direct link between environment and health. There is need for nurses to have experiences working in diverse environments to understand how to care for vulnerable populations. Premise being the nurse or patient advocate will have opportunity to reflect on this experience for meaning to better treat patients. Although patient advocates are there primarily to provide information for their patients while leaving all decision making to the patient, giving voice to the vulnerable is another concern for nurses and advocates. There is a growing concern among nurses as to how to change policy. Expansion of nurse’s role in advocacy is still relatively new in the field of medicine. The role of advocacy by nurses has been challenged primarily because physicians and social workers also have a fiduciary duty to patients in this regard. In the days of short hospital stays and even shorter doctor’s visits it is impossible for one position alone to notice other health issues patients may have and/or address other concerns. This is where a collaborative effort for solutions is essential. Cause for concern is the thought given to whether or not the nurse or patient advocate/navigator is more influenced by nursing or by medicine. Studies have shown, when presented with this question most nurses agree they endeavor to act in the best interest of the patient. Some of them even assist their patients with making the necessary connections within their community.

Copeland, V. C., & Butler, J. (2007). Reconceptualizing access: A cultural competence approach to improving the mental health of african american women. *The Haworth Press*, *23*(2/3), 35-58. doi: 10.1080/19371910802148263

*Dr. Copeland University of Pittsburgh School of Social Work, Department of Behavioral & Community Health Sciences, Dr. James Butler Department of Behavioral & Community Health Sciences and Center for Public Health Practice, University of Pittsburgh.*

Copeland and Butler (2007). Knowledge of patient advocates, physicians and other health care providers of external and internal cultural factors is essential in determining the best approach to adequate care for vulnerable populations. Cultural competency and understanding how to treat African American women with mental disorders is important. The background, social demographics, environment, multi-faceted levels of responsibility and racial hostility are all factors in the mental health status of African American women. Therefore, mental health treatment facilities should consider these socio-cultural circumstances and there adverse effects on the psychological well-being of these patients rooted in these environments. Consideration of the atmosphere in its’ socio-cultural context provides the frame work necessary in understanding and sheds light on the impact these factors have in every area of their lives. In a proposed socio-cultural model designed to facilitate the treatment solely for African American women the issues these women face were categorized into four major areas and several subsequent factors. The top areas the model call for consideration are: housing and environmental conditions, economic status, racism and discrimination, and stress and well-being. Consideration of social support networks, the educational backgrounds, and the employment environment, history of personal health practices, socialization skills, genetics, culture and gender were listed as factors. Gender has not always been at the forefront of factors affecting African women in deficiency. The focus primarily historically has been race, culture and/or economic status. Barriers of access to quality health care and the structural and non-structural barriers within the health care system on all levels are considerable contributing factors as well. Engaging with these patients in the therapeutic process, understanding cultural background, health practices, values, experiences, economic and educational levels and assessment of informal support systems are valuable.

These three groups of authors expand the traditional role of patient advocacy. All of them address the issue of the external factors contributing to the health of vulnerable populations. They are in agreement about the environmental effects on health and the mental health of African American women. They also agree a greater commitment to cultural competency of individuals in the field of patient advocacy is beneficial to the goal of lowering health disparities.

**Effectiveness of Deliberative Dialogue**

These authors explore how designed dialogue is more operative than unorganized dialogue in understanding complex issues. Data retrieved from research substantiates this ideology. The strategic application produces positive outcomes within entities previously stagnant from inadequate communication. The use of these methods can create dialogue to increase parity.

Saunders, H. H. (1999). *A public peace process sustained dialogue to transform racial and ethnic conflicts.* New York, NY: St. Martin’s Pres.

Saunders, H.H. (2001). The virtue of sustained dialogue among civilizations. *International Journal on World Peace, 18*(1), 35-44.

*Dr. Saunders the founder of the International Institute for Sustained Dialogue and the director of international affairs at the Kettering foundation*

Saunders (1999) (2001) Deliberative dialogue is communication that builds a cumulative agenda developing a common body of knowledge with the objective of transforming relationships. Deliberative dialogue is a communicative strategy process in which conflicts and dysfunctional patterns among groups within society can be altered. Deliberative dialogue is recognized as a fundamental dynamic of the democratic resolve construction and conflict resolution process. It is a form of discussion aimed at finding courses of action**.** At the core of dialogue is value of virtue. The understanding of human dignity being necessary in order to have conversations in which resolutions can come forth. Connectedness and courage is the starting point for resolution. The process can lead to bringing an entirely new world into existence. The development of human relationships can change the landscape of the world by employing everyday citizens to work with governmental systems to influence policy through participative efforts. This forum offers a boundless resource of innovative ideas. Implementation of deliberative dialogue in resolving intrinsic conflicting issues has been effective in various forums; therefore, it is reasonable it can be operative in lowering the health disparity for African American women diagnosed with a mental illness. Saunders emphasizes the fundamental actuality of dialogue, and individuals being the central element of dialogue rather than the issue.

*John Gastil,* *Burkhalter, S., Gastil, J., & Kelshaw, T. Penn State University*

Burkhalter, Gastil, and Kelshaw, T. (2002) posited that dynamics of face-to-face deliberation in small groups’ premise is triad in nature: group size, dynamics and proxemics. Moral and cultural ethical conflicts oftentimes are not clearly controlled by policy implementation. Deliberative dialogue identifies a range of possible solutions to problems; therefore, its effectiveness in virtue based conflict is feasible. Clear understanding of participant’s personal stake and experiences is vital. Consideration to the goals and values of diverse members is also crucial. Significance of accurate statistical data aides in the effectiveness transcending individual personal accounts. However, an authoritative public voice can provide credence to shared lived experiences. Deliberation should seek to include a full spectrum of views representative of the population for public benefit. Assumed common values will only diminish the consequent gain from wide-ranging views. Dialogue will not nor should it diminish the value of lived experiences each participant offers to the dialogic process. It should endeavor to create fusion and manufacture ideas collaborative in effort to benefit individuals burdened by the conflict the group convened to resolve. Increase understanding of deliberative dialogue’s efficiency and effectiveness encourages participation. Inclusion in a systematic effort for change comprised with efficacy in the process are motivating factors for group participation.

Skordoulis, R., & Dawson, P. (2007). Reﬂective decisions: the use of socratic dialogue in managing organizational change. *Emerald Insight*, *45*(6), 991-1007.

*Rosemary Skordoulis and Patrick Dawson University of Aberdeen Business School, Aberdeen, UK*

Skordoulis and Dawson (2007) of the University of Aberdeen Business School, work and conduct research in the area of organizational systematic change, employee participation and attitudes, employee commitment and decision making. In their study, *Reﬂective decisions: The Use of Socratic Dialogue in Managing Organizational Change*, they note the transformative results from employing the strategy of Socratic dialogue. Conflict resolution strategies previously based on limited communication and assumptions were reformed from the process. The methodology requires participative efforts from those in which the decisions implemented would also effect. Designed dialogue is more operative than unorganized dialogue in regards to understanding complex issues. Data retrieved from research substantiates this ideology. Researchers used a reflective approach to achieve concrete understanding of changes within organizations in which previous obscure knowledge and understanding were pervasive. Proving Socratic dialogue a useful valuable agent of change in multiple sectors. The strategic application produces positive outcomes within entities previously stagnant from inadequate communication.

Black, L.W. (2008). Deliberation, storytelling, and dialogic moments. *Communication Theory, 18*(1), 93- 116.

*Laura W. Black, School of Communication, Ohio University, Athens, OH*

Black (2008) compares storytelling with other designs of deliberative dialogues. Some organizations may choose this approach and find it beneficial in making individuals the focus. The prevalence of shared experience or commonalities are more apparent in these types of discussions. Differences and disagreements dissipate lending space to a more collective identity. The barrier presented by stereotypes and judgments are overcome and replaced with knowledge. These stories are within the scope of dialogue conducted by a facilitator or interviewer. Meaningful engagement of participants with understanding of perspectives and lived experiences can be gained. Environments conducive to expressions of understanding is prevalent.

All of the authors agree on the value of deliberative dialogue. Their approaches may differ; however, the application of the process appears to be an effective communicative source.

**Conclusion**

It is apparently clear, health disparity among African American women with a mental illness is a grave issue in the United States. However, it is not an unresolvable problem. Using strategic dialogue and field of patient advocacy/navigation to find solutions to provide insight, innovative ideas and operative solutions. Empowerment of patient advocates, community and patients will bring about a shift within the health care system and community resulting in parity.

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Skordoulis, R., & Dawson, P. (2007). Reﬂective decisions: the use of socratic dialogue in managing organizational change. *Emerald Insight*, *45*(6), 991-1007.

Ward, E. C., Clark, L., & Heidrich, S. (2010). African american women's beliefs, coping

behaviors, and barriers to seeking mental health services. *National Institutes of Health, 19*(11), 1589-1601. doi: 10.1177/1049732309350686