Culturally Specific Expression of Distressing and Coping in an African American Community Sample

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Abstract

In the African American community, racism is a significant stressor, having profound psychological, social, and physiological impacts (Clark et al., 1999). Studies have shown that coping responses may mediate relationships between stressors and mental health, with notable links between religion and mental health (Pargament & Lomax, 2013; Rosmarin et al., 2013; Watlington & Murphy, 2006; Tepper, Rogers, Coleman, & Malony, 2001). Less attention is paid to other coping mechanisms and stressors in African American communities. This study seeks to address these gaps by examining pertinent stressors experienced and strategies to manage them in an urban community sample. Thirteen mental health consumers and relative pairs (n=26 total) were recruited from two community centers in California over a 12-month period. A qualitative approach was used, comprising 26 individual interviews, focus groups, and participant observation sessions. Data was analyzed through systematic content analysis and coded by nine trained investigators. Analysis indicated recurrent themes of racial discrimination, family isolation, gang violence, and financial troubles. Additionally, religion, family support, and substance use were endorsed as coping strategies. Given these findings, culturally sensitive interventions for this population should focus on the relationships between these macrostressors and mental health, and promote more adaptive coping responses.

Introduction

Studies have found that discrimination has important health outcomes (Hunter 2010; Paradies, 2006; Williams, Neighbors, & Jackson, 2003; Williams & Williams-Morris, 2000; Clark, Anderson, Clark, & Williams, 1999). Williams, Neighbors, and Jackson's 2003 review of population based studies found positive associations between discrimination and mental health. Racism is a significant stressor across psychological, social, and physiological domains (Clark et al., 1999), but the literature overlooks other stressors impacting mental health in the African American community as well. Coping responses have been shown to mediate the relationship between mental health and stressors. While links between religion and mental health has been well documented (Pargament & Lomax, 2013; Rosmarin et al., 2013; Watlington & Murphy, 2006; Tepper, Rogers, Coleman, & Malony, 2001), more work needs to be done to delineate other coping mechanisms utilized in African American communities. To address this, the current study investigated stressors and strategies among an African American community sample.

Methods

To explore mental health distress and coping behaviors in the community, our study involved 12 months of ethnographic fieldwork, using participant observation, focus groups with community leaders and 26 individual interviews (n=26). The researchers established relationships with the African American Mental Health Coalition (San Bernardino County), and the Community Advocacy Coalition (Ventura County), two community based and population-focused organizations in the state of California. Participant observation was conducted in each site through the coordination of one or two staff members of the agency.

Participant Observations: Field researchers participated in daily activities: attending groups, getting involved in art projects and classes, having lunch, and communicating informally with members. A minimum of 30 hours of participant observation occurred at both partner sites.

Focus Groups: Researchers and partner agency staff coordinated focus groups. Researchers presented preliminary focus group questions to partner agency members, and would finalize questions as a group. Partner agency staff identified and invited approximately 8-12 community leaders (n = 16 – 24), with the aim of better understanding cultural idioms of mental distress and coping behaviors.

Interviews: The Cultural Formulation interview was used to conduct 26 semi-structured interviews. The CFI was shared with the partner agency for modification or edits. In addition the Short Suicide Stigma Form and Devaluation-Discrimination Scale (a scale assessing awareness of community stigma) were self-administered after the CFI. In both sites, half of the interviews were for consumers that met inclusion criteria for a mental health disorder, and the other half were interviews for a mental health consumer's friend or family member.. Verbal consent was obtained prior to the interview and the average interview lasted 50 minutes.

Nine highly trained coders conducted systematic content analysis of all data sources. Codes were derived using an inductive reasoning method. There were 28 codes in total. Data was coded as stress, trauma, conflict, coping, and discrimination. Disagreements were resolved with group discussion.

Results

Participants were 55% female, with a mean age of 41.4 years. Qualitative analysis indicated recurrent themes of racial discrimination, family isolation, gang violence, and financial troubles. Difficulties "finding a good job," being isolated from paternal figures, and "liv[ing] in area[s]" where "every other day, someone gets shot" and attempts to "recapture ... a respect ... they, as members of the African American community, have often been historically denied" foster a "culture of people who are angry and frustrated." Theses stressors were both historical and present day concerns, with historical traumas of slavery and segregation impacting present day mental health. Religion, family support, and substance use were endorsed as coping strategies. "Family and God" were repeatedly identified, with "talking" or "be[ing] with the family" helping participants manage times of distress and "prayers" and "read[ing] the bible" used to make "downs go up." Substance use was seen as "self-medication."

"I think that it helps because all African American people, well everyone struggles, but ***as a race we were brought here as slaves.*** *Even though that was over three hundred years ago. There's a* ***lot of things that we're still struggling with*** *and I don't mean everywhere, but there's still a lot of* ***institutional racism*** *going on." – Interviewee*

"… it seems to be ***easier to talk about, um, mental health*** *problems, or mental health in the positive sense, ah,* ***in the context of faith*** *… it just feels like a more natural conversation … because when you go to church you know the Pastor will talk about the problems that you have." – Focus Group Participant*

Code	Definition	Example
Stress	A reference is made to pressure, distress, strain or anxiety. May be double coded depending on the type of stress mentioned.	*"The stress seemed to be deriving from witnessing gang activity … loss/ no access to jobs, and everyday stress of survival." – Field Notes*
Trauma	A reference is made to more severe stressors outside the scope of typical human experience (Williams et al., 2003). This can be current or historical.	*"And I usually get depressed at nighttime because I was in a battered, an abusive relationship where my husband, he got off, he worked nights. So when he got home at night, that's when all hell would break loose. You know if he had a bad day he'd take it out on me, or he would try to take it out on the kids but I wouldn't let him." – African American Interviewee*
Conflict	A reference is made to a disagreement, argument or fight. May or may not be a physical altercation.	*" … and in moments when they are already hurt and you know they feel like they should retaliate, and I felt like that's probably some kind of mental health issue right there because you can easily get sucked into the chaos you know, and the stupidity and you know, retaliate because you think that it's the right thing to do at that time." – African American Interviewee*
Discrimination	A reference is made to individuals being discriminated against or treated unfairly. This code is also used if references to bias, prejudice or stereotypes are made.	*"We weren't treated as individuals, we were treated as a group." – African American Interviewee*
Coping	A reference is made to how an individual deals with or manages their distress or mental illness. Double coded with mental health services if method of coping occurs through counseling or other professional means.	*"… it seems to be easier to talk about um mental health problems, or mental health in the positive sense, ah, in the context of faith… it just feels like a more natural conversation … because when you go to church you know the Pastor will talk about the problems that you have." – Focus Group Participant*

Table 1. Codes with definitions and examples

Conclusion

Discrimination was identified as a significant stressor. Macrostressors, or "large-scale, systems-related stressors" (Williams et al., 2003), of financial distress, gang violence, and historic forms of trauma were also prominent stressors for clinical and non-clinical populations. From a young age, these are salient concerns with racial tensions exacerbated by mental health stigma and compounding stress and feeding the cycle of violence. Results indicate use of both adaptive (religion, family support) and maladaptive (substance use), coping mechanisms that do not alleviate individuals' responses to stressors (Clark et al., 1999). In light of these findings, culturally sensitive interventions for this community must be mindful of the relationship between several macrostressors and mental health, not solely focus on racism. Mental health providers should also be aware of how historical stressors continue to shape mental health and help seeking behaviors. It should be noted however, that results of this sample may not generalize to all members of this ethnic group. Finally, interventions should identify the specific type of coping mechanisms being utilized by this group to promote the utilization of more adaptive responses.

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