

“WE DON’T TALK ABOUT THAT”: MENTAL HEALTH PROMOTION BY
PARENTS IN AFRICAN AMERICAN COMMUNITIES

by

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A Thesis submitted in partial fulfillment of the requirements for the degree of Master of
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by

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Bachelor of Arts
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DEDICATION

This work is dedicated to my loving parents—Clarence E. Watkins & Rhetta J. Watkins—for supporting me through every hardship and success. Thank you for putting my mental health first and helping me become the person I am today. This research is dedicated to the millions of Black Americans who fly under the radar of our mental health services. Mental illness transcends racial lines and affects every community. It is our job to do better for the communities left behind. This work gives tribute to the voices unheard. For the Black and African American families who tackle mental health challenges and obstacles—you are not alone, and we will do better for you.

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LIST OF ABBREVIATIONS

Acquired Immune Deficiency Syndrome	AIDS
Communication Privacy Management Theory	CPM
The National Alliance on Mental Illness	NAMI
Human Immunodeficiency Virus.....	HIV
Severe Mental Illness	SMI
United States	US

ABSTRACT

“WE DON’T TALK ABOUT THAT”: MENTAL HEALTH PROMOTION BY PARENTS IN AFRICAN AMERICAN COMMUNITIES

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This research investigates parental promotion of mental health in African American communities. This study uses Communication Privacy Management theory (CPM) (Petronio, 1991) and Systems theory (Von Bertalanffy, 1972), in order to explore the motivations and attitude formations of adolescent mental health at the parental level. In essence, this study plans to explore the intersections between generational communication, race, and mental health. Qualitative interviews were conducted with 10 African American parents; gauging perception and past interactions with adolescent mental health. Results indicated African American parents show knowledge gaps and understanding of mental illness and mental health services. Major findings of this study unearthed relationships between the Black Church, generational education, and collective awareness of mental health in the African American community. Most of the participating parents acknowledged the heightened visibility of mental illness in modern

society; however, many parents failed to acknowledge a connection between race and mental health. These findings suggest a multitude of influences at play during the disclosure and promotion of mental health by African American parents and adolescents. Robinson (2012) posits, “Telling a [relational member] you have depression allows for the [member] to either reject you or offer support. It may allow for the understanding of depression as a disease, or it may open the door for insensitive remarks which may be detrimental to the relationship” (p. 1). By highlighting familial relationships during the disclosure process, potential tensions arise, complicated further by the addition of race.

Keywords: adolescents, African American, Black, guardians, health communication, mental health, parents

CHAPTER ONE: INTRODUCTION

A really big conversation and idea that I'm getting introduced to right now is black mental health. 'Cause for a long time that wasn't a thing that we talked about. I don't remember it. I don't remember people talking about anxiety; I don't remember, when I was growing up, that really being a thing (Callahan-Bever, 2017)

As a very prominent and acclaimed Hip-Hop/Rap artist, the 3-time Grammy award winner Chance the Rapper echoes similar sentiments prevalent in the African American community. These words from Chance the Rapper, spoken in an interview with *Complex* magazine, (Callahan-Bever, 2017) bring a salient issue into mainstream focus; communication about mental health in the Black community. As an article in *Mental Health America* (2017) explains, while recent discussions of mental health have surrounded majority White populations, Black Americans face unique, considerable, and overlooked challenges when traversing the mental health industry. From social pressures to socioeconomic factors, African Americans face a multi-point battle in combating mental health stigma and perception: (1) current mainstream narratives depict mental illness as a primarily White phenomenon; (2) mental illness is steeply stigmatized in African American communities; and (3) current mental health services neglect cultural factors, key for successful treatment and information dissemination (Zavala, 2017). These

issues prevail despite the Health and Human Services Office of Minority Health (2008) estimating, African Americans are 20% more likely to experience serious mental health problems than the general population. Furthermore, African Americans are less likely to seek treatment for mental health problems than members of other social groups (Cook, Zuvekas, Carson, Wayne, Vesper, & McGuire, 2014; Jimenez, Cook, Bartels, & Alegria, 2013; Lo, Cheng, & Howell, 2014).

Doctors and healthcare providers are encountering an overlooked variable when treating mental illness in minority adolescents: parents. Vital to the introduction of healthcare and health attitudes, parents and guardians hold a key role in constructing the mental health beliefs of their children. Unfortunately, mental health issues in the Black community are often trivialized and belittled by parents and guardians (Allen, 1997). This leads Danielle Zavala (2017) from The National Alliance on Mental Illness (NAMI), Massachusetts branch to state bluntly, “ignoring mental illness in children won’t make it go away” (p. 1).

In a 2015 study, researchers found that the rate of suicide had doubled in Black children ages 5 to 11 from 1993 to 2012 and further found that suicide had become the third leading cause of death among Black adolescents ages 15-25 (Tavernise, 2015). This was one of the first studies in recent years to find higher suicide rates in Black children and adolescents compared to their White counterparts. Because of this, there exists a need to reevaluate mental health in Black adolescents. For the purpose of this research, an "adolescent" will be defined as a person within the age range of 15-25. This expanded definition of adolescence is supported by a 2013 new directive from the child psychiatrist

of London's Tavistock Clinic, who suggests an extension of the age range based on brain development from the previous age cap of 18 years old, to 25. This would allow child psychologists to continue working with adolescents, through the toughest predicted mental health years of 18-21 (Wollaston, 2013). While there may be some reservations about referring to a 25-year-old as an adolescent this study will differentiate *young adolescents* (ages 15-18) from older adolescents or *emerging adults* (19-25).

Furthermore, with new insurance policies allowing children to stay on their parent or guardian's health insurance until age 26, the role parents and guardians play in the mental health conversation has significantly increased. This paper responds to the necessity for researchers to examine mental health beyond the illnesses themselves and explore the familial relationships that are pivotal to the construction of mental health.

Important Concepts

A few terms need to be clarified before diving into the literature review: *mental illness*, *self-disclosure*, and *parental health promotion*. The National Alliance on Mentally Illness x defines *mental illness* as a group of disorders which cause a severe disturbance of feeling, thinking, and relating, lasting a duration at least two weeks or more (2016). As the American Psychiatric Association (1994) further breaks down, mental disorders are classified by significant changes in behavioral and/or psychological patterns caused by distress. Moreover, NAMI reports 1 in 5 children, or potentially 50 million kids, will have a serious mental illness within the ages of 13-18. As Ruggeri et al. (2000) observe, there has been a push in recent years to focus mental health services on these cases of severe mental illness (SMI). However, Ruggeri et al. argues the unclear

nature of SMI has clouded researchers' ability to hone their analyses. To avoid this foggy lens, the operationalization of mental illness in the context of this literature review will be expanded to any case that meets the previously outlined conditions. It is critical to reverse this trend of hyper-focused dictations, as any individual with non-neurotypical behaviors is vulnerable to the effects of stigma.

To avoid the effects of stigmatization self-disclosure of socially framed defects has become common practice. Jourard (1958) defines *self-disclosure* as the ability to communicate and share personal feelings. The access to consensual disclosure is an essential part of well-being and mental stability. Hendrick (1981) highlights the necessity of being willing to discuss information about themselves to others. Self-disclosure is vital in the formation of intimate relationships, as it serves both the functions of knowing the self and an attempt to be better known by others (Jourard, 1958). It is this duality which operationalizes self-disclosure in this paper. Encouraging a person to open up about the circumstances they face is the only way to properly assess their mental state. The negative effects of mental illness are amplified when one does not self-disclose; when we hide ourselves, we lose touch with who we are (Jourard, 1958). Factors which block this channel of self-disclosure are directly responsible for the misconceptions surrounding mental health; this rhetorically places the development of our relationship with our parents or guardians, our first intimate interactions, under the spotlight.

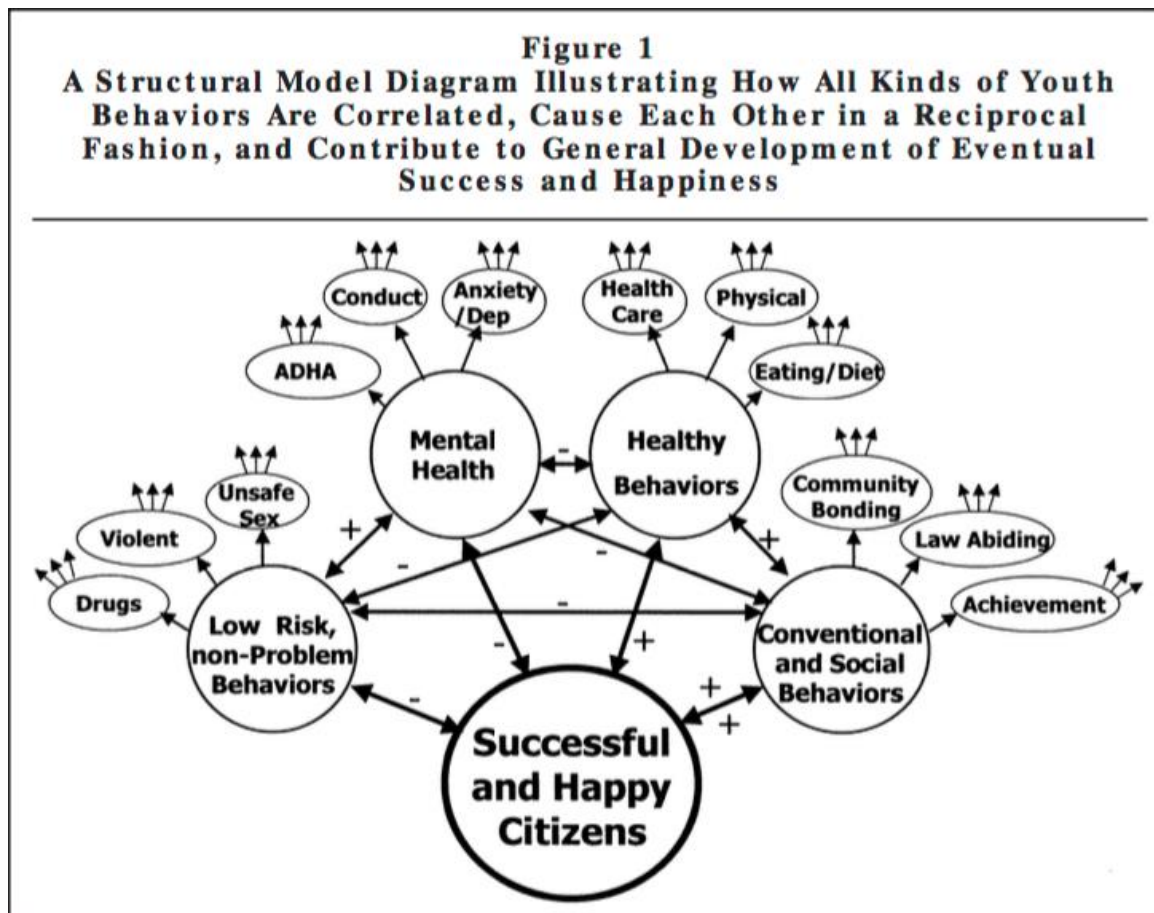


Figure 1: Flay's structural model diagram

Finally, aside from parental influence, this study also conceptualizes *parental mental health promotion* as actions or non-actions taken by a parent or guardian which influence the way mental health is promoted to their children. Flay (2002) views health promotion as a process for enabling individuals to increase control over their health. Health promotion moves past individual behavior towards a broader range of social and environmental interventions. Flay's analysis explores health promotion in correlation with positive youth development. As Figure 1 exhibits, Flay (2002) shows childhood behaviors are highly correlated across the board. As they can often predict and map subsequent childhood behaviors Flay argues for these patterns to be highlighted.

The promotion of health during youth, whether it is positive promotion or negative promotion, could directly affect a myriad of other developmental behaviors. Eva

Jané-Llopis furthers this argument, stating the promotion of mental health works; suggesting positive reinforcement by a parent, yielded a higher probability for seeking information or help from mental health services (Jané-Llopis, Barry, Hosman, & Patel, 2005). The more parents reinforce the importance of getting help, the more likely kids will seek help if they experience problems. Because of this, the promotion of mental health by a parent is significant for analysis.

For the purpose of this foundational research, positive mental health promotion starts with parents opening a dialogue. Under this train of logic *active negative health promotion*, *passive negative health promotion*, and *positive health promotion* all exist as pathways parents can take when engaging in discussions of adolescent mental health. This research views negative mental health promotion as adverse behaviors, passive or active, which reinforce negative stereotypes, misinformation, and/or dissuade adolescents from information and health seeking for mental health. On the flipside, positive mental health promotions highlight accurate methods of interaction, support, and discussion of mental health between parents and children. For some households, merely having a bona fide discussion about mental health is a war in its own right.

Preview

This research study will identify African American parents as a unique socio-culturally positioned factor influencing African American adolescent mental health attitudes. Attitudes determine passive and active reactions to disclosure, acceptance, coping, topic avoidance, and information/help seeking. This work explores questions of how African-American parents make sense of mental health, especially concerning their

own children. This study will garner a heightened understanding of this phenomenon by illuminating scholarly relevance, employing methodological testing, and reporting relevant findings. Robinson (2012) argues for the extrapolation of these intersections, urging African American parents to understand the roles they “play in those relationships as [parents], who gain personal knowledge about a [child’s] physical and mental health” (p. 1). It is not enough for researchers to merely understand the inner workings of mental health and causes of mental illness, the literature needs to reflect the potential outcomes once mental health concerns are confirmed.

CHAPTER TWO: LITERATURE REVIEW

Mental Health and Society

Stigma. Corrigan (2000) uses a model of social attribution to elaborate and extend the shortcomings of previous research with regard to stigma and mental illness. As Corrigan explains, research on disease dimensions does provide some insight on how people understand illness. However, these dimensions do not suggest how knowledge affects the behavioral responses to stigma and other events. As previously proposed, simply knowing about a disease removes social interactions/effects from context.

Corrigan (2000) uses attribution theory, a model of human motivation and emotion based on the assumption that individuals search for causal understanding of everyday events, to proffer two foundations of mental illness stigma: *stability* and *controllability*. Stability refers to the temporal nature of cause; how does the illness progress when viewed from a long-term position? This includes the label of “severe or serious” to a mental disorder. If treatment of the disease seems “hopeless” or incurable, given the nature of the illness, stereotypical actions are projected on the individual spurring stigmatized reactions (Corrigan, 2000). From a short-term perspective, controllability refers to the amount of volitional influence an individual exerts over a cause. How manageable is the mental illness day-to-day? If the illness is less severe, what actionable steps is the individual taking to normalize their behavior? This structure frames responsibility solely around the person with the illness; and offshoots its own stigmas (Corrigan, 2000). The need to rely on medication, therapy, or other coping

strategies may be active steps taken to control mental behaviors, but invites social criticism based on the fact of needing these resources in the first place.

Feldman and Crandall (2007) explore the dimensions and forms of perpetuated stigma in mental illness. They highlight the crux of mental illness stigma is social rejection and its impacts. The effects of stigma are as harmful as the effects of the actual disorder itself:

The first is from the direct effects of the disorders—cognitive, affective, and behavioral difficulties that limit one's ability to function effectively. The second kind of harm is...social rejection, interpersonal disruption, and fractured identity that comes from the stigma of mental illness (Feldman, & Crandall, 2007, p. 138)

By phrasing these outcomes as effects, Feldman and Crandall dispute the embedded nature of mental illness stigma; furthermore, they categorize and rank the various levels of stigma based on type of disorder and number of disorders. They articulate the three factors involved in social rejection: *personal responsibility for the illness*, *dangerousness*, and *rarity of the illness*. This article lays an initial framework at which to view this stigma; conveying the base judgmental factors which are present in every mental disorder.

Corrigan (2004) elucidates the way stigma interferes with treatment of mental illness. He argues many people who could benefit from mental health services opt not to pursue them, or fail to fully participate in treatment once they have begun. This disconnect is directly driven by stigma; specifically, to avoid the label of mental illness

and the harm it brings people decide not to seek or fully participate in care. Corrigan (2004) further explains that stigma produces two kinds of harm which may impede treatment or participation: It diminishes self-esteem and robs people of social opportunities. The constant bombardment of misunderstandings faced by individuals who disclose mental health problems erodes self-esteem. This makes it easier to say nothing, rather than deal with the stigma. Furthermore, admitting to having mental illness or even disclosing a visit with mental health professionals can have social impacts, resulting in lost opportunities. Jobs, promotions, social events, and even renting an apartment can be out of grasp for individuals who have a mental illness. There are few legal safeguards protecting vulnerable people from this kind of discrimination. Corrigan (2004) calls for establishing more programs to combat mental health stigma. This is especially important in African American communities where, as will be discussed in depth later, stigma surrounding mental illness is high and inhibits self-disclosure and discussion about mental health problems.

Corrigan (2005) proffers strategies to aid in this endeavor. The author extends the previously outlined framework of stigma, explaining that the core problem that people with mental illnesses face is public reactions to their disabilities. Living with negative reactions often leads to self-stigmatization, and although laws such as the Americans with Disabilities Act are designed to help decrease discrimination for mental health problems, much progress still needs to be made. For his part, Corrigan describes practical strategies for dealing with public stigma and self-stigma. For example, Corrigan (2005) suggests contact between those with mental illness and those without may be one of the most

effective ways to diminish stigma, illustrating the importance of communication about mental health issues. However, the lack of communication about mental health issues can perpetuate and amplify stigma.

Mental Health and the African American community

With a better understanding of mental health perceptions and social stigma, it is imperative to dig even further and explore the interplay between the Black community and mental health. Samovar and Porter (1972) defines culture as the cumulative deposit of knowledge, meanings, beliefs, experiences, attitudes, and conceptions of self, acquired by a large group of people that manifests itself in language, thought, and in forms of activity and behavior. Furthermore, members of respective cultures are taught to conceal thoughts and feelings concerning certain subjects, such as mental illness (Basvanthappa, 2007). Culture influences rules (social norms) about health behaviors, attitudes, and beliefs, including about mental health.

What sets Black communities apart from mainstream culture is their counter-cultural positioning. Black communities have developed cultures in parallel with or opposition to the governing culture it has had to bear to survive (Lachmann, Eshelman, & Davis, 1988). As Hopson (2007) elucidates, White Americans rarely examine the source and meaning of inequality in society, and to the extent they are aware of the interplay between White identity and social advantage, they most often choose not to challenge this order. Moreover, Robinson (2012) notes that many White Americans fail to see how centuries of slavery, segregation, racial discrimination, and institutionalized racism has granted them social and political privileges. Conversely, Black people are far too

conscious of the racial inequalities experienced at every level of citizenship. Because Black America has had to view the world through a different pair of eyes from the start, various levels of counter-cultures were created out of a sense of coping, rebuilding, and survival. For the Black community specifically, interactions with societal consensus have always involved some form of friction, and the mental health industry is no different.

Disclosure. Allen (1997) provides a useful analysis which highlights salient racial/ethnic differences in communication studies fostering further extrapolation to mental health and disclosure patterns. As Allen (1997) notes, race is a societal cue we use to form perceptions which could result in misleading assumptions about ethnic group interactions. For this context, various ethnic cultures recognize mental illness differently. For those with mental illnesses, race is just as strong as any other motivator in self-disclosure. Because Blacks are aware of discrimination, evident by the racial inferiority projected on them, they are less inclined to disclose their mental health problems, in fear of increased discrimination (Allen, 1997). Allen further argues that since Black people are taught at an early age that race matters, the weight of this consciousness permeates every avenue of disclosure. This is why disclosure concerning mental health issues are so important in African American communities.

Kohinor, Stronks, and Haafskens (2010) examine the issue of selective disclosure in Black communities, focusing on diabetes. While the authors do not deal with mental illness specifically, they do highlight disclosure factors among ethnic communities which affect all health disclosures. *Perceptions of social environment, perceptions of the illness, and perceptions of illness management* are all factors that are both influenced by culture

and help determine whether or not individuals disclose their illness (Kohinoor, Stronks, & Haafskens, 2010). The author's results conclude that individuals with ethnic backgrounds may have varying levels of disclosure about health issues for fear of compromising their image and background.

In some cultures, talking about disease is taboo and can lead to communal conflict (Feldman, & Crandall, 2007). In the Black community for example, mental illness stigma stems at least in part from the realm of abstract spirituality, meaning that the base fear and rejection of mental health disclosure comes from the belief that mental illness is caused from misdeeds going against religion (Anglin, Alberti, Link, Phelan, 2008). To come out as mentally ill is synonymous with coming out as spiritually ill. Therefore, individuals in the Black community are less likely to disclose about mental health problems. African Americans are more inclined to believe that this disclosure opens the door to a bigger admission than just about mental health status. This becomes an admission, because of the social environment, that is stigmatized with guilt, making Black people with mental illnesses feel disempowered, weak, and shameful.

Dutta and Basu (2008) explore the intricacies of simply discussing health concerns with a doctor in the Black community. Dutta and Basu explain that social positioning within a culture or family has a massive effect on perceptions about medical care. They explore how men in rural West Bengal engage with structural resources and sanction agency by formulating communicative strategies within their constraints to take care of their health needs and those of their families. They note,

Men in rural Bengal come from their acknowledged role as primary providers of healthcare for their families. Men are not only primary, and at times, sole earners in families; their responsibilities extend into the realm of securing access to preventive health services for their families, and to organizing optimum use of available treatment options (Dutta, & Basu, 2008, p. 561).

This perspective is crucial to understanding how different social roles hold various levels of agency in regards to medical decision making. Like mainstream America, the Black community's economic structural follows a patriarchal system within the family. These patriarchal structures prioritize male guardians as leaders of the household. Because of this, individuals may feel they do not have the agency to disclose, seek medical support, or even acknowledge the existence of a mental disorder. This lack of visible agency allows for mental health researchers to gloss over culture and put the burden of information seeking on the patient. Dutta and Basu (2008) lament, "culture is an 'acted document,' it is 'public', it consists of 'socially established structures of meaning' and webs of significance within which people are suspended" (p. 561).

Mistrust. Brandon, Isaac, & LaVeist (2005) examine the influences that overlooked levels of mistrust Black communities have towards trust in health care industries. When medical mistrust exists, it is nearly impossible to effectively communicate health issues, creating insurmountable obstacles to treating mental illness. The objective of their study was to examine race differences in knowledge of the Tuskegee study and the relationship between knowledge of the Tuskegee study and medical system mistrust. The Tuskegee syphilis experiments exposed hundreds of Black

people to the disease for the purposes of observing the effects of the disease (Thomas, & Quinn, 1991). With no intention of curing them of their newly contracted syphilis, researchers watched as these test subjects perished over time. This was the most notable but certainly not the only instance of grand mistreatment of Black people by the medical industry. Brandon et al. (2005) traced knowledge of the Tuskegee study to modern day mistrust of the health care system by members of African American communities. While their results found no significant connection of traceable knowledge and mistrust to the Tuskegee studies, they did find high levels of mistrust stemming from broader historical and personal negative experiences with the health care system.

Gamble (1993) notes that after the Tuskegee experiments the federal government strengthened regulations to protect the subjects of human experimentation. These increased safeguards, however, have not erased the mistrust and fear of many African Americans who were concerned that they too would be abused in the name of medical research. Gamble (1993) asserts, the Tuskegee Syphilis Study symbolizes for many African Americans the racism that pervades American institutions, including the medical profession. This lasting legacy leads Alpha Thomas, a Dallas health educator at University Hospital who often confronts the legacy of Tuskegee, to proclaim:

So many African American people that I work with do not trust hospitals or any of the other community health care service providers because of that Tuskegee Experiment. It is like if they did it then they will do it again. (Thomas, 1991, p.1503)

Unfortunately, the strengthening of safeguards and reforms in research standards have been insufficient to change this fear.

The attitudes and practices of medical researchers towards African Americans also cannot be discounted just because progress has been made. Gamble recalls: “Once at a job interview, I was told that Black people are not included in clinical studies because ‘it is a well-known that they are noncompliant.’”(Gamble, 1993, p. 37). Moreover, in the past, most clinical research trials used White men as the standard or norm from which to extrapolate data to the rest of the population. White men were presumed to be a homogenous—non diverse—population that had fewer confounding factors. Meanwhile, members of minority groups and women were frequently excluded from clinical studies. The author argues the importance of Blacks to be included in clinical and public health studies to examine diseases and conditions that disproportionately affect African Americans, such as research examining why the suicide rate among Black children being higher than White children (Tavernise, 2015).

Corbie-Smith et al. (1999) frames the Tuskegee syphilis study as a metaphor for research subject abuse. The authors do this to highlight the consequences of this metaphor in researching HIV/AIDS epidemic. In this study, Corbie-Smith et al. (1999) attempted to identify the factors which kept African Americans from joining clinical trials. As Gamble previously noted, the authors of this study also found there was a variable of researcher exclusion that needed further addressing. However, the authors found an interesting pattern related to cultural knowledge among participants. Some of the participants opted to believe health information passed down from familial ties,

regardless of scientific-supported research, leading to the conclusion that culture explanations of health are more believable when they come from trusted sources.

An interesting finding of Corbie-Smith et al. (1999) is the way the participants described the consent document. Participants phrased the standard consent form as legal protection for researchers and funding institutions, rather than describing its use as a method of increasing their understanding during the consent process. The balance between the legal rationale and moral justification of informed consent may not be recognized as a goal by the patient or physician. When so many inconsistencies exist within a phenomenon, credibility always defaults to the most trustworthy source; and in this instance, the value of Black cultural perception of the health industry, trumps medically sound suggestion (Hammond, 2010).

Perception of mental illness. With the variable of trust outlined as salient, it is pivotal to see what exactly informs the Black community's perception of mental illness, and explore how these perceptions enact themselves in real life. Schnittker, Freese, and Powell (2000) tackle the task of delineating the racial differences in perceptions of treatment and mental illness. These scholars found African Americans were more likely than White Americans to reject the notion of mental illness altogether. As Dutta and Basu (2008) alluded, culture and spirituality play pivotal roles in the erasure of mental illness in Black communities. Schnittker et al. (2000) asserts that Black individuals were less inclined to believe mental illness is caused by genetic or family-based explanations of psychological disorders. The study suggests Blacks were more skeptical of genetic and family explanations because of the resemblance to arguments used to criticize Blacks and

justify systemic racism. This train of thought asserts the stigmas associated with mental illness (i.e. dangerous, little self-control, and demonic/possessed) bare eerie similarities to the stereotypes projected on African Americans. A fear of further stigmatization, leads to a desperate need to separate from the source of further stigma. Push back spurs the creation of alternative explanations, such as: karma, moral deviance, and/or compromised faith. As previously outlined in Jourard's (1958) conceptualization of self-disclosure, any factor which blocks or erases the channel of self-disclosure, further stigmatizes mental illness which doesn't achieve the intended goal of dodging stigma, it merely changes the direction. Ultimately, this research suggests the misconceptions of mental illness fostered in African American communities not only reinforce the stereotypes Blacks so avidly try to avoid, but further silences groups who have spent centuries finding their voice.

This notion of intra-misconception is supported by Waite and Killian's (2008) study on the examination of Black women's perception of depression. Their study found that despite fitting traditional classifications of depression, Black women were less likely to view their feelings as such, opting to frame them as just part of being Black. In collocation, Kendrick, Anderson, and Moore (2007) studied Black male perceptions of depression. Their findings suggest that African American men framed their depression as being "stressed." In both cases, the variable of mental health was erased and subsumed into the constant discrimination which permeates through Black communities. These studies assert mental illness went untreated because emotional stability was not considered important of enough to seek treatment.

Anglin et al. (2008) extends and elucidates the hypothesis of selective treatment seeking. With telephone interviews of 118 African American and 913 Caucasians who had a family history of psychiatric hospitalization, participants were told narratives surrounding someone who either suffered from depression or schizophrenia. These respondents were challenged to determine whether or not professional help could improve a patient's condition, or whether the patient could improve on his or her own. This study showed that Black participants were more likely to believe that mental health problems would improve on their own, going away without treatment. Because the Black community does not see mental illness as chemical or biological imbalances, the necessity for psychiatric treatment becomes rhetorically moot (Schnittker et al., 2000). These scholars suggest that even though the effectiveness of treatment was proven, Black Americans were not inclined to use these services. This illuminates the need for reframing mental illness in a physical (rather than cultural or spiritual) context. As Burnette (2011) notes, African Americans are more likely to seek treatment for persistent headaches than anxiety disorders.

Thompson and Alexander (2006) examines the reactions and attitudes of therapy from 44 African American participants seen at a university clinic. The clients were randomly assigned a White or Black therapist for their 10 therapeutic sessions. Thompson and Alexander (2006) framed their study around the perceptive effectiveness of therapy when discussions of race are prompted by different races. The study emphasized the higher rating of effectiveness given by African American clients to Black therapists, suggesting that race not only plays into the conceptualization of mental illness

but also extends to the perception of effective care when psychiatric services are used. Whether or not the therapist initiated or did not initiate discussions of race was insignificant. There was a pattern of trust among same race pairings. Thompson et al. (2004) explored a similar query of Black perceptions of psychotherapist and psychotherapy. Participants reported, even though race should not matter in therapy, they often believed that psychologists were insensitive to the African American experience.

To summarize the analysis thus far, it is challenging to get the Black community to acknowledge mental illness as a chemical process (Schnittker et al., 2000). There are challenges to get African Americans to trust healthcare services (Gamble, 1993). There are challenges to get African Americans to seek treatment for potential mental health problems (Anglin et al., 2008), and there are different perceptions of effective treatment among African Americans based on the race of the therapist (Thompson, & Alexander, 2006).

Boyd-Franklin (1989) confronts all of these barriers in her examination of Black families in therapy. As one of the most comprehensive books of its time, surrounding Black families and psychological services, Boyd-Franklin puts emphasis on the utilization of cultural strengths in therapy. Dr. Boyd-Franklin also gives appropriate attention to the therapist's use of self and the subtleties which are crucial in relationship building, and could improve perceived effectiveness of treatment. She outlines influences which could interrupt therapy with a diverse Black family, such as racism, racial identification, skin color, socioeconomic status, inner-city living location, single-parent, and middle-class Black families. Boyd-Franklin's Multisystems Model guides family

therapists to intervene with Black families at multiple levels, including individual, familial, extended family, church/community networks, and the social service system levels (Boyd-Franklin, 1989). This persistent penetration into the Black family's culture could improve mental health services for African Americans. Boyd-Franklin (1989) urges every mental health physician in contact with Black families to consider this Multisystems Model, as it could provide consistent strategy for permeating through barriers in Black communities, debunking misconceptions and combating mental health stigma, one family at a time.

Adolescent Mental Health

Conceptions of mental illness in youth present different obstacles in the mental health treatment narrative. Powers et al. (1989) highlights three themes which guide current research about the mental health of adolescents: (1) focusing analysis of inter-individual differences to describe variety in adaptation; (2) the integration of biological, psychological, social, and cultural variables in models of adolescence; and (3) an emphasis on the developmental aspects of adolescent mental health. These themes attempt to bridge the gap between adult projections of mental health and cross apply integral variables to adolescents. Kazdin (1993) supports these themes, but advocates for the examination of behaviors and conditions which place adolescents at risk for adverse outcomes, highlighting the urgent need for prevention and treatment.

Briggs-Gowan, Horwitz, Schwab-Stone, Leventhal, and Leaf (2000) frame mental health treatment in adolescents through the responsibilities of pediatrics. This study examined the role pediatricians play in facilitating effective discussions about emotional

behaviors in children. The conclusions assert pediatricians are well-placed to identify and refer children with psychiatric disorders. However, most parents do not discuss behavioral/emotional issues with their pediatricians. Briggs-Gowan, et al. (2000) challenges readers to question why this hesitation exists. Does denial of early on set emotional disorders stray parents away from talking with pediatricians (2000)?

Rohner and Britner (2002) argue that the communicative disconnect between parents and doctors directly influences the child's perception of emotional behaviors. Their study postulates a universal relationship between perceived parental acceptance-rejection and psychological adjustment. Rohner and Britner (2002) made substantial connections to apply this viewpoint world-wide, based on three other mental health issues: (1) unipolar depression and depressed affect; (2) behavior problems, including conduct disorder, externalizing behaviors, and delinquency; and (3) substance abuse. These scholars highlight the importance of parents and guardians communication with adolescents concerning mental health.

Adolescent mental health stigma. Children adjusting to perceived parental acceptance/rejection of mental health initiatives is only the beginning of developmental alterations based on social acceptance. Chandra and Minkovitz (2006) utilized self-administered questionnaires to 274 eighth graders, concluding more girls than boys would ask a friend for help about an emotional concern whereas more boys turned to a family member first. Chandra and Minkovitz's (2006) research showed that boys had less mental health knowledge, and thus experienced higher mental health stigma, than girls. Furthermore, parental disapproval and perceived stigma helped explain the relationship

between gender and willingness to use mental health services. Stigma reduction efforts were deemed most effective with the active involvement of parents who would openly address differences in knowledge and exposure to mental health issues.

Yeh, McCabe, Hough, Dupuis, and Hazen (2003) contextualized race and ethnicity in adolescent mental health stigma, via the cultural support of barriers separating children from mental health services. This study was predicated on four hypotheses: (1) African American, Asian/Pacific Islander American, and Latino youth would have higher levels of unmet mental health needs compared to Whites; (2) Parents of ethnic minority youth would report a greater number of barriers to mental health services for their children than White parents would; (3) The pattern of greater barrier endorsement by ethnic minority parents compared to White parents would persist across different barrier types; and (4) Barrier endorsement would be related to unmet need for mental health services. While hypotheses 2 and 3 were not supported, hypothesis 4 was found to be significant and supported the Schnittker et al. (2000) findings showing mental health service avoidance in ethnic communities.

African American adolescent mental health. Zimmerman, Ramirez-Valles, Zapert, and Maton (2000) explored the *resilience* of African American male adolescent mental health. This study examines *mental health* and *perceived control* of Black male adolescents, highlighting the relationship between strong mental health and sociopolitical autonomy. To justify their logic, Myers (1989) proposed that the mental health of African American youth is an outcome of the interaction between individuals and their social environment, suggesting youth's emotional problems are adaptive problems, rather than

intrinsic or pathological. Zimmerman et al. (2000) supported this assertion, explaining that the effects of “personal helplessness on mental health and self-esteem were moderated by youth’ feelings of control in social and political domains” (p. 745). African American adolescents with sociopolitical control believe they can take real actions in social and political domains. It is this variable of control that offsets low perceptions of personal helplessness. In the current moment, the feeling of hopelessness possessed by adolescent African American males is present and constantly reinforced. However, helplessness does not necessarily lead to poor mental health (Fernando, 1984).

As suggested, feelings of control and self-efficacy may alter the effects of helplessness on mental health. Zimmerman, Ramirez-Valles, and Maton (1999) applied the results of a longitudinal study to the stress-buffering effects of African American adolescent mental health. This study examined parental and friend support, stressful life events, alcohol and substance use, delinquency, and psychological symptoms of 173 urban, male, Black adolescents. While almost all of the factors tested showed little significance, one variable remained salient: parental support. Zimmerman et al. (1999) showed that *parental support* was a predictor of less anxiety and depression for Black adolescents over time. However, while their findings suggest parental support acts as an insulator from anxiety and depression, their study also found that adolescent mental health concerns do not necessarily activate increased levels of parental support.

Angold, Erkanli, Farmer, Fairbank, and Burns et al. (2002) build on these conclusions, arguing that African American youth are not seeking the help they need. The scholars studied the mental health actions of over 4,500 rural youths ages 9 to 17 in North

Carolina, finding that African American and White youth were equally likely to have psychiatric disorders, but African Americans were less likely to use specialty mental health services. McMiller and Weisz (1996) contend it is not that Black adolescents simply choose not to use mental health services. Instead, the autonomy of a minority adolescent is regulated by a multitude of factors, including control, mental health industry perception, family and socioeconomic status.

Breland-Noble (2004) provides a clearer sense of the current ways African American families deal with adolescent mental health. The Breland-Noble model is a conceptual psychology-based model of mental health behaviors for depressed Black adolescents. The model reflects the varied relationships which contribute to the identification of help-seeking behaviors of Black adolescents (Breland-Noble, 2004).

This model hypothesizes:

Black adolescents and their families do not use a systematic method for identifying [mental illness]; that Black adolescents and their parents consult different entities for help, and that Blacks perceive mental health clinical care as a majority culture phenomenon for people with severe psychopathology, thereby making these services irrelevant for them. (p.3)

This model supports earlier claims of cultural influences outside the Black family (e.g. the Black church) and extends mental illness severity as a factor of motivation, suggesting that African American parents and families are less likely to treat depression in adolescents, unless the condition of mental health is too severe to ignore.

Topic avoidance. The ‘suspension’ within culture (Dutta, & Basu, 2008) and strict adherence to communal norms speaks to the larger trend of specific topic avoidance in Black families. Guerrero and Afifi (1995) explore general topic avoidance between parents and children. The authors claim topic avoidance, or the spectrum refusal to speak or acknowledge certain subjects of conversation, increases as children become adolescents. Guerrero and Afifi (1995) hypothesize that avoidance-based behaviors are critical tools adolescents use to claim privacy and build autonomy. However, the purpose of this avoidance is to still maintain a close relationship with the parent. In essence, this article suggests topic avoidance serves as an unavoidable process of adolescent autonomy. Commonly avoided topics include: relationship norms, prior sexual/romantic history, negative behaviors, and conflict-inducing subjects. The avoidance process is selective and predicated on the goal of maintaining parental approval (Guerrero, & Afifi, 1995).

Bakken and Brown (2010) specify topic avoidance patterns of African American and Hmong youths. The authors support Guerrero and Afifi’s (1995) claim that avoidance acts as an autonomy developing tool. However, they argue that the communication of ethnic experiences in Black families complicates this development. Specifically, African American parents communicate to their children what it means to be Black. During these conversations, often referred to as the *Black talk* (Funderburg, 1994), parents focus much of their efforts on teaching about their own culture and the value of diversity (Bakken, & Brown, 2010). Moreover, African American families perceive discrimination and focus their efforts on preparing their children for anticipated racial

bias (Hughes, 2003). Bakken and Brown (2010) assert that as adolescents communicate less and less with their parents about activities and relationships, the more parents will worry about their children's retention and adherence to ethnic group traditions, and the more they will fear potential discrimination during time spent away from home. These factors are some of many which “may contribute to both adolescent and parent perspectives on appropriate adolescent disclosure or secrecy” (Bakken, & Brown, 2010, p. 364).

Parental Mental Health Promotion

While Boyd-Frankin's (1998) work was monumental in tackling family therapy in Black families, the examination of family-centered therapy clumps the individuals within the nuclear family as a set obstacle in implementing effective treatment. In modern society, the issues faced between Black communal interactions with mental health professionals defy us to look deeper at the interactions within the family. As Dutta and Basu (2008) note, the social positioning of a child within a Black family holds limited agency. Wollaston (2013) explains, the adolescent age range of 15-25 years old is the most vulnerable age group to come-in-contact with mental health professionals. The previously defined conceptions of self-disclosure and parental health promotion collide here. Since positive intervention is centered on dialogue, and self-disclosure is necessary for positive mental health (Hendrick, 1981), interference with cohesive dialogue and disclosure are emblematic of negative mental health promotion.

Negative mental health promotion. The social positioning of parents and guardians, in relation to their children makes the promotion of mental health attitudes in

adolescents nearly impossible to avoid. This calls for the examination of negative versus positive parental mental health promotion.

Active negative promotion. Davis-Kean (2005) combines previous assumptions and extends the power of a parent's mentality to adolescent social expectations in a study that tested how socioeconomic status, specifically parents' education and income, indirectly relates to children's academic achievement through parents' beliefs and behaviors. Davis-Kean's (2005) research found less emphasis on socioeconomic status and more on the level of education the parent received. Furthermore, while there was no value judgment given to expectations based on race, this study did confirm the process health promotion was different among the races. These findings suggest that regardless of economic realities, the way parents carry themselves, positively or negatively, has drastic effects in a child's behavior. Like Rohner and Britner (2002), the example of expectation setting by the parent is a negative form of parental health promotion since it does not open up dialogue and forces an outcome.

Gershoff (2002) provides another example of active negative health promotion via corporal punishment. The article does a great job at remaining neutral on the morality of corporal punishment, offering to instead focus on corporal punishment in association with the child mental health outcomes. This included higher levels of immediate compliance, aggression, and lower levels of moral internalization concerning mental health (Gershoff, 2002). The author postulates that corporal punishments diminish child agency, increase mistrust, and potentially close channels for consensual self-disclosure.

Passive negative promotion. While active promotions of health are easy to identify and extrapolate, negative passive promotions of mental health have the potential to be just as influential, while exponentially harder to identify. This type of health promotion is especially harmful, as it involves variables parents may be unaware of or simply refuse to take into account. Repetti, Taylor, and Seeman, (2002) coin the notion of “Risky Families”, or families characterized by conflict and aggression in their relationships, which foster cold, unsupportive, and neglectful atmospheres. While this would appear to be a more active choice, guardians of ‘risky families’ either have not or do not have to confront their role in creating these environments. Repetti et al. (2002) studied the effects these atmospheres have on adolescent mental health, finding that these families tend to suspend emotional health as a primary care concern. However, Repetti et al. (2002) offers a new perspective, suggesting:

Parents can learn to become more effective and nurturing, but if they remain in high-stress environments marked by grinding poverty, high crime rates, inadequate employment opportunities, and insufficient support systems, then the success of such efforts will be compromised. (p.359)

Repetti also helps clarify that however salient a parent’s role is in their child’s mental health development, parents and guardians are not exempt from the necessity of strong social support.

A parent’s need for strong social support is often overlooked, especially during times of divorce. Single parents have been previously identified as markers to consider in adolescent mental health developments. However, Strohschein (2005) seeks to uncover

the challenges which could reshape a child's mental health trajectory during a divorce. Strohschein departs from previous literature surrounding divorce effects on children, by characterizing child mental health as a dynamic developmental process. This reframing removes the static motion of mental health development traditionally characterized as either decreasing negatively or increasing positively. This vantage point conveys the potential for a child to go on an emotional roller coaster throughout the divorce process, as high levels of anxiety and depression surge during this time (Strohschein, 2005). Situations of passive health promotion may have unclear centers of causation. However Drotar (1997) posits that the more adaptive a family relationship and parental perception becomes, the higher probability there is of positive psychological adjustments.

Socioeconomic factors. Both active and passive health promotion share a key variable of perpetuation, socioeconomic status. Turner, Finkelhor, and Ormrod (2006) explore the communicative effects of lifetime victimization on mental health. The researchers delineate the differences between stigma and victimization, arguing that stigma is a product of internalized misconceptions and victimization is a product of external factors out of one's control, such as ethnicity, being of lower socio-economic status, and living with a single parent or stepfamilies. Turner et al. (2006) suggest, even originally neurotypical adolescents could exhibit mental disorders, such as high anxiety, because of victimization. These distinctions are salient as it provides a three-dimensional perspective that illuminates other avenues of mental stress for adolescents, while elucidating factors which justify parental mental health conservatism.

Black and Krishnakumar (1998) echo Turner, explaining living in a neighborhood characterized by structural disadvantage could have adverse effects on the mental stability of adolescents. Particularly, when children are exposed to settings with high rates of crime, violence, delinquency, substance use, abuse, and poverty, it puts undue stress on emotional development. While psychologists are well suited to intervene in problems associated with low-income neighborhoods, as Boyd-Franklin (1989) would advise, most psychological services have been directed toward children who are experiencing problems, leaving less focus on population-based or preemptive interventions that prevent problems before they occur (Black, & Krishnakumar, 1998).

Aneshensel and Sucoff, (1996) explicate the need for such preemptive measures, in their exploration of mental health contextualized in neighborhoods. They found that adolescents who lived in neighborhoods perceived as dangerous or crime riddled were more likely to develop complex relationships with depression, anxiety, oppositional defiant disorder, and conduct disorder. They argue when viewing mental illness in young people, the adolescent and parent/guardian cannot be separated from the structure of residential neighborhoods. Samaan (2000) further argues that while race complicates this scenario, it is a critical perspective that needs to be taken into account. Unfortunately, the current literature seems to focus more on White populations in vulnerable neighborhoods, but neglects families of color. The interplay of these scholars suggests that culture drives mental stability in adolescents, specifically culture created in the family between parent and child, culture passed through racial diversities, and culture perpetuated via neighborhood.

Black children experience disproportionate shares of the burden of poverty and economic loss and are at substantially higher risk than White children to experience socio-emotional problems (Mcloyd, 1990). Mcloyd explains that the economic hardships experienced in impoverished diverse families, not only produce undue stress on the child, but also lead parents to downplay disclosure of emotional problems by their children. Economic loss diminishes the capacity for supportive, consistent, and involved parenting and renders parents more vulnerable to the debilitating effects of negative life events. Furthermore, economic hardship puts most mental health services out of reach, and given the complicated relationship between mental health and the African American community, Black families are more inclined to negatively prioritize (if they choose to prioritize) healthy mental development (Mcloyd, 1990). This research highlights the influences that a parent or guardian's reaction to adolescents' mental health concerns have on the children's perceived agency towards achieving positive mental health.

Positive mental health promotion. Drotar's (1997) viewpoint examines positive health promotion, or the potential for a parent/guardian to appropriately facilitate a dialogue where the adolescent feels comfortable enough to disclose mental health status or concerns. Mann, Hosman, Schaalma, and de Vries (2004) assert that positive health promotion starts with the promotion of self-esteem in adolescents. Their study shows the importance that self-esteem has on an individual's mental health.

Poor self-esteem. The outcomes of negative self-esteem can be multilayered. Poor self-esteem can result in "a cascade of diminishing self-appreciation, creating self-defeating attitudes, psychiatric vulnerability, social problems or risk behaviors" (Mann,

Hosman, Schaalma, & de Vries, 2004, p. 360). The salience of this observation examines poor self-esteem as a cause, and a consequence of problem behavior. While the causality of poor self-esteem is situational, the authors concentrate on self-esteem as a potential risk factor for mental and social outcomes such as: (1) mental disorders with internalizing characteristics, such as depression, eating disorders, and anxiety; (2) poor social outcomes with externalizing characteristics including aggressive behavior, violence and educational exclusion; and (3) risky health behavior such as drug abuse and not using condoms.

Positive self-esteem. Mann et al. (2004) showed beneficial outcomes of positive self-esteem were associated with mental well-being, happiness, adjustment, success, academic achievements and satisfaction. Their study also suggested positive self-esteem lead to better recovery after severe diseases. Self-esteem is a pivotal risk and protective factor linked to diversity of health and social outcomes. Thus, positive self-esteem can serve as a key component in parental health promotion. The protection and promotion of self-esteem can provide adolescents with the agency to freely discuss emotional problems.

Fonagy, Steele, Steele, Moran, and Higgitt (1991) illuminates the salience of comprehending mental disorders in children as well as the role parents should play, arguing for enhanced information-seeking by parents in regards to the potential mental states of their children. The authors reframe popular notions of security, emphasizing a parent's ability to confidently anticipate and understand the child's mental state. But when you interpret "understanding" differently, our scholars unintentionally raise

questions about a parent's ability to accept and provide for a child with a mental disorder. Ultimately, a parent being able to make her/his child feel understood does not secure prolonged mental stability (Fonagy et al., 1991).

Logan and King (2002) researched parents' ability to identify depression in their adolescents and seek professional help. They hypothesized that by enhancing these abilities to identify and understand signs of depression health campaigns could be targeted and tailored to depressed adolescents. The variable of adolescent-parent communication provided an interesting finding, suggesting that conscious attention to enhanced communication "did not influence parental recognition of [depression]...[however] better communication was associated with increased parental identification of depression among girls in the sample" (Logan, & King, 2002, p.302). This supports similar findings by Chandra and Minkovitz (2006) that suggest that there may be a stronger role played by gender in adolescent parent communication about mental health than was previously thought.

Logan and King (2001) push the conceptions of positive health promotion further by examining the parent's role in facilitating mental health services. Their study highlighted the adolescents' confidence level of navigating mental health services with stunted parental appearance. Logan and King identify separation and individuation as primary developmental goals of adolescence. However, most adolescents who use or come into contact with professional mental health services require the attention and assistance of adults to facilitate the complex process of seeking and obtaining such services. While this study found higher stress levels associated with adolescents

interacting with mental health professionals, the reframing of adolescents (as *younger adolescents* and *emerging adults*) could have drastically altered this study. The premise of this study is salient, as it highlights how a passive role can still exemplify positive health promotion.

To shift from a review of literature to theoretical frameworks, this study utilizes Von Bertalanffy's (1972) systems theory and Petronio's (1991) communication privacy management theory (CPM). Both of these theories tackle specific sections of this phenomenon. Systems theory explores the interconnectivity of group relationships. This theory was chosen to explore the unique connection between the African American community and the Black Church. This theory provides insights surrounding the effects one system (e.g. the church) may have on another (e.g. church members and their families). CPM theory explores the way people communicate private information. This theory was chosen because it is grounded in the observations of interpersonal decision making. This theory informs how the management of private or sensitive information can change depending on context.

Systems Theory

Ludwig von Bertalanffy's general systems theory was originally developed while testing the "scientific method", but has extended across various fields (i.e. biology, psychology, and communication). Across all systems, there is one asserted truth of this theory: knowing one part of a system, enables us to know something about another part. Von Bertalanffy (1972) illustrates systems theory in small group communication, as groups which are inherently open systems. Groups are influenced by a litany of

independent variables: such as openness to environment, interdependence, input variables, process variables, and output variables.

Kuhn and Boulding's (1974) extends systems theory, stressing the role of *decision making* in moving a system towards equilibrium. Communication, transaction, and interaction, all act as a catalyst for systems to achieve equilibrium. As Kuhn and Boulding's (1974) assert, "*Culture* is communicated, learned patterns...and *society* is a collective of people having a common body and process of culture" (1974, p. 154, 156). By viewing society as a system, culture can be seen as a pattern in the system. Further, the study of systems follows two general approaches: *cross-sectional* and *developmental* (Kuhn, & Boulding, 1974). Cross-sectional approaches deal with interactions between two systems, while the developmental approach deals with changes in a system over time.

Moreover, Walonick (1993) outlines three standard approaches when evaluating systems and subsystems: *holist*, *reductionist*, *functionalist*. The holist approach examines systems and subsystems as complete, functioning units. A reductionist approach dives deeper to examine the subsystems within the system. The functionalist approach looks outside of a system in order to examine the role of the subsystem in relation to the larger system. All three approaches recognize the existence of subsystems operating within a larger system (Walonick, 1993).

Family. Hill (1971) explores systems theory in relation to family units. There are four primary conceptualizations used in the family development framework: (1) Conceptualizations of a family's "systemness" is categorized by the systems ability to be

relatively closed, boundary maintaining, equilibrium seeking, purposive and adaptive; (2) Conceptualizations of structure, like norms, position, role, role clusters, and role complexes notifies what recurring, repetitive, and reciprocal features may be seen; (3) Conceptualizations of goal orientation and direction, is illuminated by the task performing and functional abilities of the family; (4) Conceptualizations of orderly sequences is observable in the family over its life history (Hill, 1971, p.11). This framework is crucial for analyzing the various roles within communal mental health. Systems theory explores how systems can influence and restructure each other. This theory informs how outside systems and influential institutions (e.g. the Black church), can inform parental perception and thus, informs adolescent perception.

Communication Privacy Management Theory

Communication privacy management theory (CPM) provides an ideal framework for examining communication about mental health within African American families since it illustrates the ways people make decisions about revealing and/or concealing private information. This extends the analysis observed by Systems Theory, where the relationship between the family and other systems influence each other. CPM explores the interworking's of information disclosure and privacy within the family. In other words, Systems Theory explores outside influences, while CPM explores inside influences within families.

Petronio (1991) breaks down five core principals of communication privacy management theory: (1) People believe in the ownership and right to control their private information; (2) Individuals control their private information via the use of personal

privacy rules; (3) When others are told or given access to a person's private information, they become co-owners of that information; (4) Co-owners of private information need to negotiate new mutually agreeable privacy rules about external disclosure; (5) When co-owners of private information don't effectively negotiate and follow mutually held privacy rules, boundary turbulence is the likely result. Given the focus of this study it is imperative to understand the how, when, and what happens after the disclosure of mental health concerns between Black parents and adolescents. Petronio's multifaceted theory, elucidates privacy management on the health, race, and family communication levels.

Health communication. Petronio et al. (2013) makes some crucial clarifications concerning CPM, noting that when considering the processes of disclosure, it is important to know *disclosure* is not what is revealed but is rather the process of telling. Moreover, *private information* is what people disclose within CPM theory. What establishes private information is the information that has the potential to produce and magnify vulnerabilities if shared with others. Nevertheless, it is more than that; it is setting and negotiating boundaries which are at the crux of this theory. In a healthcare setting, clinicians tend to assume just as much ownership as the patient (Petronio, Helft, & Child, 2013). Because of this mutual ownership of private information, coupled with the formal scripts of health care professionals, it can be difficult for patients to feel a strong sense of efficacy when negotiating boundaries. This increases the potential for patient-provider mistrust to rise exponentially. Moreover, it is the sensitive nature of health-related issues which complicates the disclosure process. With regard to mental health, the process of

telling one's story of mental illness invites stigma and influences who controls the narrative, where individuals open themselves up to questions of fact and credibility.

Race communication. Docan-Morgan (2011) extends CPM to intercultural and racial communication. Their study explored families formed through transracial adoption, applying CPM to racial topic avoidance. Docan-Morgan (2011) identify two reasons for racial topic avoidance: *self-protection*, and *relational protection*. In the case of race and other intercultural sensitivities, sharing instances such as name calling or harassment might cause vulnerability, embarrassment, or the reliving of negative or painful experiences. Racially sensitive subjects tend to be avoided as it puts the discloser in a dangerous position of backlash, directly affecting mental health. Second, relationship protection of friends, family, and colleagues was deemed salient. Bringing up racial traumas or private information could potentially spur the ostracism of close relational members.

Family communication. Finally, family communication provides a unique perspective in which to view CPM. Given the nature of familial relationships, there is a longevity variable in play during every disclosure. You are more likely to have multiple interactions with the same family member, spanning a variety of years, making the information shared and boundaries constructed more valuable. Child and Westermann (2013) studied children's likelihood to accept parental friend requests on Facebook. Using CPM, the scholars examined the complexities of information disclosure on social networking sites as well as the complications of allowing everyone to see what is posted. While the study showed that most of the youth did accept their parents' friend requests,

their findings suggest power differentials inherent in the parent-child relationship may be influencing the young adults' perceived ability to decline such requests. This raises the question: is it still disclosure, if you feel compelled to comply? As Petronio (2010) argues, explaining CPM permeates family communication via the individual privacy boundaries versus the collective family privacy boundaries. Petronio (2010) explains that either implicitly or explicitly, family members functioning as recipients of private information are perceived to have a responsibility for information that other members reveal to them or to whom they give access. As a result, privacy management may be understood on multiple interpretive levels across and among individuals and collectives.

Research Questions

Originally, this study's research questions were derived from the literature review which suggests a correlation between parental mental health promotion and adolescent mental health autonomy. These points of inquiry led to the following research hypothesis:

- *How does parental perception of mental health influence healthcare decision-making for their children?*
- *Does mental health promotion by African American parents influence mental health perception of African American adolescents?*

These questions attempted to explore the spectrum of a parent's influence on mental health during their child's adolescence. However, after the study was conducted, more relevant research questions surfaced. Boyatzis (1998) explains, the nature of some studies require an inductive and reflexive approach instead of a deductive approach. This

happens more so with qualitative based research than with quantitative based research. After further review of the literature, and evolution of this research, the following research questions were derived reflexively:

RQ1: What are the mental health attitudes held by African American parents?

This question proves salient in establishing a base for the analysis of parental perception of mental health and the subsequent connection to mental health services. This question directly speaks to the most saturated literature on this phenomenon; testing theories of expected perceptions against the realities presented in the data.

RQ2: How do attitudes towards mental illness affect the way parents communicate mental health to their children?

The independent variable of this question gauges the influence of mental illness perceptions in relation to how parents communicate with their children, the dependent variable. The purpose of this question is to highlight the differences between passive beliefs and active communication. By knowing these boundaries and where they cross, this research could isolate the key factors shaping the promotion of mental health by African American parents.

RQ3: What role does the Black Church play in the attitude formations of mental health in African American families?

The Black Church represents the independent variable, measured against the mental health perceptions of African American families. The purpose of this question is to garner insights about the dependent variable, mental health attitudes within African

American families, in an effort to uncover the level of influence religion has on mental health discussions.

RQ4: How does parental perception of mental health influence healthcare decision-making for their children?

This question was still deemed relevant after reviewing the data. The independent variable in this question measures parental perception, juxtaposed to the dependent variable of decision-making. The purpose of this question is to highlight the salient roles African American parents play in their charges' mental healthcare decisions. Moreover, this question seeks to understand the motivations behind these perceptions, and the degree to which healthcare decisions are guided by these belief systems.

These questions attempt to make it easier to understand disclosure and discussion patterns of mental health in African American communities.

CHAPTER THREE: METHODS

Black vs. African American

Before addressing the methodological framework, it is important to make a salient differentiation between African American and Black communities. Until now, the adjectives *Black* and *African American* have been used interchangeably, as the research claims presented have applied to both identity sects. However, the scope of this research study runs into some ideological impasses. Recruitment for this study was done primarily from Black churches, as it provides the largest sample of localized collections of African American families. While the colloquial label is *Black church*, the institution itself is entrenched in African American ideology. That may sound contradictory and confusing, but Younge (2007) helps elucidate the differentiation between Black vs. African American.

Younge explains, *African American*, as a term that was popularized in the 1980s, is used to describe a particular experience of Black Americans of African descent. *Black*, simply refers to someone of African descent; including, but not limited to Black people from the Caribbean, Africa, French-Creole, Latin and South America. In short, all African Americans are Black, but not all Blacks are African American. Philogène's (1999) book *From Black to African American: A new social representation*, dissects the intersections between culture and race; arguing, the African American identity is derived from the culture, traditions, and experiences evolved from slavery. While Philogène (1999) openly criticizes the term *African American* as a vacuum label of multiculturalism

with a monolithic outcome, she ultimately highlights the necessity for accurate ideological representations.

Harris (2014) further explains this issue as African American ideology being steeped in ritual, religion, and shared experience. Consequently, the institution of the Black church falls under this category; hence, sampling from Black churches primarily will inherently intersect and be driven by African American ideology. In correspondence with systems theory, Von Bertalanffy would argue a significant relationship between the belief systems of African American families and the Black Church. The Black Church has served a pivotal role as an informal social service provider throughout its history. Studies have shown that churches provide a wide range of prevention and treatment-oriented programs, which contribute significantly to the psychological and physical well-being of their Church members (Blank, Mahmood, Fox, & Guterbock, 2002). Church resource services include: substance abuse assistance, health screenings, education, and support. Von Bertalanffy's (1997) theory suggests correlative relationships between systems of salient value, the Black Church provides specific context to the African American community and the cultural dissemination of attitudes towards mental health.

There was no interrogation of the participants as to their ancestry or affiliations, meaning there could be a mix of African American and Black participants. This precise delineation was highlighted to heed Philogène's (1999) warning; to provide accurate representations of African American and Black communities. It would be unethical to generalize these findings to a monolithic Black experience; hence, this differentiation is

appropriate. Consequently, the focus of this study is on African Americans and any findings or conclusions should not be generalized to all Black people.

Thematic Analysis

The methodology selected to study communication about mental health issues in African American families is thematic analysis, employing a combination of qualitative interviews and focus groups. Boyatzis (1998) provides an excellent description of this methodology and offers justification for its use in this context. Based in qualitative studies, thematic analysis allows for researchers to translate qualitative information into qualitative data. The utilization of themes to categorize interpretations satisfies Boyatzis' (1998) fourth condition of thematic analysis: "A way of systemically observing a person, an interaction, a group, a situation, an organization, or a culture" (p.5). Given this research phenomenon registers under several of these indicators, there exists a necessity for theme extraction.

Qualitative quasi-structured interviews with single and/or coupled African American parents, was deemed most appropriate for this study. The only requirements were being African American and holding parental status. It was not necessary for their child or adolescent to have mental health concerns, as the interviews served as an exploration of mental health perceptions held by African American parents.

Thematic analysis is a search for themes that emerge as being important to the description of the phenomenon (Daly, Kellehear, & Gliksman, 1997). The process involves the identification of themes through "careful reading and re-reading of the data"

(Rice & Ezzy, 1999, p. 258). This is a form of pattern recognition within the data, where emerging themes become the categories for analysis.

The coding process involves recognizing or seeing important moments and encoding it (recognizing it as something) prior to a process of interpretation (Boyatzis, 1998). A “good code” is one that captures the qualitative richness of the phenomenon (Boyatzis, 1998, p. 1). Boyatzis (1998) further defines a theme as “a pattern in the information that at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon” (p. 161).

In addition to this inductive approach, Crabtree and Miller’s (1999) template approach was also employed. This involves a template in the form of codes from a codebook to be applied as a means of organizing text for subsequent interpretation. Fereday and Muir-Cochrane (2006) explain, when using the template approach a researcher defines the template (or codebook) before commencing an in-depth analysis of the data. The codebook is sometimes based on “a preliminary scanning of the text” (p. 83). For this study, the template was developed based on the research questions and the theoretical framework. After the qualitative interviews and focus groups of African American parents are conducted, the transcripts were coded for relevant themes.

Procedures

Participants. Recruitment strategies for participating African American parents were implemented at local churches, social media ad posts, and university students from the Black Student Alliance (BSA), along with recruiting respondents from membership groups which tend to favor a particular view on the issues addressed in the study

(Gunther, 1992, p. 155). The goal was to increase the probability of finding participants willing to discuss their views on mental health and parenting. The requirements for the participants: (1) they are in fact parents and/or guardians; and (2) they racially/ethnically identify as African American.

Welcome and briefing. During this time the researcher introduced himself, thanking the participants, and explained the purpose of this study. Participant questions of further clarification were taken before beginning each of the remaining steps of the study. These procedures were approved by the George Mason University Institutional Human Subjects Protection Review Board.

Qualitative Interviews. The interview portion of this study ranged from 20-45 minutes and was conducted either in-person or via telephone, based on the convenience of the participants. The participants were informed about the age representation of their charges in this experimental design, most notably delineation between child (14yo and below), *younger adolescent* (15yo-18yo), and *emerging adult* (19yo-25yo). This interview followed semi-standardized and open-ended design, focusing on topical questions surrounding mental health perception, while allowing for open responses and conversation with the participants. See Appendix 2 for the interview schedule used in this study.

Follow-up questionnaire. After the interviews, participants were asked to complete a short questionnaire. This involved gathering non-identifying demographic information: including sex, age, and ethnicity. Furthermore, participants were given the

option to write any closing thoughts about the topics discussed. This provided an opportunity for ideas not comfortably expressed in the oral interview to be recorded.

Debriefing. During this time, participants were once again thanked for their participation, anonymity insured, and the experimenter revealed the full nature of the study.

Participant Demographics

Of the ten interview participants recruited for this study, eight different churches were represented surrounding the Northern and Central Virginia areas. Of the participants there were seven women and three men. When asked to indicate their age, two participants indicated the age range 41-55 years old, while the remaining eight participants identified with the range 56 years old and up. Occupations of these participants were more concentrated: four participants identified as educators/teachers, two identified working in construction or factory-based work, three revealed they were retired, and one participant did not disclose their occupation. Moreover, the education levels of the participants varied: four participants admitted to either completing or participating in college, three alluded to getting a high school education, while the remaining three did not disclose the level of education received.

CHAPTER FOUR: RESULTS

The interview questions explored the relationships between Black parents that attend a predominately-Black Church, and adolescent mental health. African American parents are ideal publics for this research, because they ultimately influence the beliefs of the entire family (Harley, 2005). The lessons parents instill in their children directly affect their children's future actions when seeking healthcare services. The identification of mental health perceptions of Black parents offers key insights to where those beliefs originate.

Themes

After conducting and transcribing the interviews, responses were then coded for relevant themes. These interviews revealed eight salient themes in the interview data: (1) *Surge in mental health awareness*; (2) *Generational education gap*; (3) *Parent-child relational shift*; (4) *Misconceptions of mental health concerns*; (5) *Trust vs. mistrust of mental health professionals/providers*; (6) *Unprepared for discussion*; (7) *Rationale by faith*; and (8) *Importance of study*. Appendix A illustrates the coding process via highlighted passages by theme color. The themes were randomly assigned a coding color: Surge in mental health awareness highlighted in *purple*; Generational education gap—highlighted in *blue*; Parent-child relational shift highlighted in *grey*; Misconceptions of mental health concerns highlighted in *red*; Unprepared for discussion highlighted in *green*; Trust vs. mistrust of mental health professionals/providers highlighted in *pink*;

Rationale by faith highlighted in *yellow*; and Importance of study highlighted in *brown*.

All quotations are pulled from interview transcripts which can be found in Appendix A.

Surge in mental health awareness. In nearly all the interviews conducted, participants said they observed a heightened awareness of mental health and mental health related issues within recent years. This theme revealed to be impromptu of the questions asked. Most participants voluntarily admitted to recognizing mental health more in recent years than in others. For example, Participant 1 provided reasoning behind the surge in mental health awareness:

I've definitely seen more support; I think maybe in the last five years, because of the increase in teen suicide. It may have always been there but people just didn't hear about it.

Likewise, Participants 1 and 6 suggested that mental health visibility has increased within "the last few years," other participants ranged the surge more broadly. As Participant 9 noted,

Well I think they have learned a lot of things about mental health in the last 30-40 years. You know they use to have those Asylums, where they just called people insane, and there was nothing else to do than strap them down and drug them. So that has really changed.

Notably, Participant 9 connects mental health visibility with medical advancements, suggesting a correlation between the dissemination of mental health information and breakthroughs in treatment.

Generational education gap. All respondents 56 years old and older alluded to a generational gap in knowledge about mental health. In contrast to modern mental health visibility, participants highlighted the lack of education they received grew up.

For example, Participant 2 emphasized the education gap, stating:

You dealing with Black people, they probably didn't know anything about it.

Their mind is gone or something like that, they didn't know that much. The education definitely wasn't there. We sure didn't learn about it in school, about the mentals. And of course, I'm looking at people born in the 1920s and 1930s.

That was my family. It wasn't much education, and a lot of them didn't even go to school. Parents couldn't always afford it, and nobody made them go. You didn't know about that did you?

This quotation shows the effects of the minimal visibility of mental health in previous generations. During the interview, for instance, Participant 2 nonverbally seemed slightly ashamed or embarrassed for not knowing more about mental health. Participant 5 noted that while mental illness existed in the past, it was not as socially prevalent or labeled as mental illness. The interviewee suggested a salient reason, for the education gap:

[Take] ADHD, they have these different illnesses now. Which they had back then, but they had so much more family structure back then...you know like the community raises the children. They were not treated as mental health things.

Participant 5 seemed slightly agitated while giving this response. This was a common theme amongst the participants, when presented with subject matter they were less

familiar with. Participant 10 explored this agitation, prevalent throughout the African American community:

I know in our black community, it's a little bit of a taboo. It's not to be talked about. Everyone would always say "we don't talk about that." Just from growing up myself as a child, I can remember some of the older generational people saying. They just didn't expect it to be something in the black community.

This recollection by Participant 10 suggests a generational cultivation of mental health avoidance in the African American community.

Parent-child relational shift. A significant number of interviews alluded to a stronger, or changed, parent-child relationship as their children aged and transitioned from adolescences to young adults. This theme derived mainly in response to Q3, *How have you maintained your relationship status with your children?* The responses overwhelmingly indicated an increased positive relationship with their children over time.

When explaining how they reached their current relationship with their children, Participant 5 stated:

We have wonderful relationship now. In the beginning, well I'd say the teenage years, it wasn't. You know you were a parent first. And children don't seem to like the structure you have to give them; but then they start to appreciate it later in life. That's when your relationship grows stronger, because they can identify what you've been teaching them all these years. They learn to appreciate it.

In addition to mapping the challenges of developing parent-child relationships this passage highlights the lifelong duration of parental influence.

Misconceptions of mental health concerns. There were multiple instances where the conceptions of mental health were factually skewed or unclear. For example Participant 6 said, “Alright, so you know well people say its mental health as usual, mental issues. A lot of that, I don’t fell is so much mental, more emotional.” There was a strong confidence behind this explanation, despite the emotions, being mental processes.

Further, there were beliefs that mental illness is something that strikes later in life based on trauma or hard life experiences. Participant 6 explained, “How they were brought up, if something bad happened to them. I don’t think that someone is mentally unstable, just because they think differently.”

Participant 8 articulated stigma as a major obstacle in the Black community, stating, “I am beginning to understand that, the stigma associated with mental health for so long, has impeded the progress of many families, in ways we are just starting to learn about. And I think that, from my personal experience, mental health was looked at as a negative. If a person had needed or took advantage of some tool or some professional guidance for mental health, it was seen as a weakness” (Appendix A). Participant 8 exhibited a somber tone while delivering this response. The misconceptions of mental health were made evident through a vocal shift in tone.

Trust vs. mistrust of mental health professionals/providers. There was also a strong belief in the value of taking their children to mental health professionals, but some still felt hesitant. Participants 1, 2, 4, 5, 7, 9, and 10 all indicated in some way that they

trust mental health professionals. Common phrases: “I would seek support, help, guidance, some professional intervention”; “I would take ask the opinion of a specialist”; and “We would definitely seek professional help.” There was little to no hesitation in their confidence to seek professional help, though there were some apparent hesitations on the next steps after seeking help.

Conversely, some participants (and sometimes even those who expressed trust) doubted the effectiveness of mental health professionals. Participants 5 and 6 expressed doubts about mental health professionals and, in particular, the idea of treating mental illness with pharmaceuticals. Participant 6 stated, “We had [mental illness] back then, growing up, but they didn’t control it with medication. So when they have problems now, they blame it on mental health.” The respondent’s vocal inflection alluded to some slight annoyance, while delivering the claim. Participant 5 gave a full explanation for their mistrust:

A lot of people get diagnosed and put on all this medication, and that’s all about money. For me, that alters the way they behave. Whether it’s to make them calm down, I think they’re doping them up and most of it is just, to me, more so based off of Big pharmaceutical companies making money...All of that type of stuff, putting kids in special education, when it’s really just for a kickback. And how a lot of schools got busted for doing that, you know some schools get \$15,000 per child that is in special ed. And they were using the money to fund sports teams and stuff. But it was predominately in your, where you have predominately black students. There’s just a lot of crazy stuff happening, man.

The participant was impassioned and seemed concerned about the perceived corruption of mental health services.

Unprepared for discussion. Many participants were reluctant to start mental health discussions with their families and community. Every participant admitted to not discussing mental health with their families, and most felt uncertain about their ability to start conversations. As Participant 1 put it, “What would I say?! ‘You want to talk about mental health?’ That would be odd.” Or as Participant 2 said, “None of my close family members ever had any mental health problems, so it just never really came up” (Appendix A). In short, in multiple instances, participants showed a reluctance to actively discuss mental health.

However, almost all of the participants who were uncomfortable starting a discussion about mental health followed this statement by noting that they would *listen* to their child if they came up and asked about mental health concerns. Unfortunately, by avoiding mental health until it is brought up, parents put the responsibility of discussing mental health on their children.

Rationale by faith. Most participants, whether actively or passively, mentioned faith as the foundation of their belief systems. Participant 2 asserted, “I think all things is controlled by the Lord. And perhaps through spiritual help, he will answer your prayers. And so far it has. It helps me on the day to day things” (Appendix A). Responses like this were pretty common, in different iterations. Participant 10 extended religion as a motivating factor in a variety of health decisions:

Because of my faith, my belief that I have, I would certainly pray for my children. That's just who I am so certainly that is something I would do. And just be there for them, if they need me...I certainly turn to the Church. And it is part of the community, for me, my family will always be a force for me. Family means my sisters and brothers, and of course my husband. My family and church are my primary sources for support.

Further, Participant 7 made an observation about the Black community, calling the aforementioned quotations commonplace to hear:

The suggestion that if you take it to God or take it to Church, then it will be fixed. Take it to a pastor, even. Umm, my father is a psychologist and he says one of the biggest challenges he has is, you know people assuming the pastor can make things OK, when you know the pastor isn't necessarily trained in counseling, at least towards mental health. You know, so we sometimes mistakenly think that we can find salvation, or find, uh, a solution, in places other than mental health professionals.

While few participants openly disclosed turning to the Church for guidance about mental health, most participants still highlighted the importance of religion in their beliefs and as a source of support when facing life challenges.

Importance of study. Towards the conclusion of the interview, the final question asks all participants about any final or lingering thoughts about the discussion; almost all participants mentioned the importance of this research. Regardless of stances regarding

mental health, some parents thought this subject matter was unknown from an African American perspective. Participant 7 noted,

I think that this topic, is really worthy of exploration. And I think that there needs to be more how [African Americans] either communicate concerns of mental health, how people communicate around the issue of mental health. And strategies for how to be more supportive in that, from a communication perspective (see Appendix A).

Participant 7 was very passionate when responding to the final question. This passion is also reflected in the final response of Participant 10:

I think your topic is one that is certainly very prevalent. I think it is important. I think mental illness is more widespread in the black community than we realize or would like to accept. I am proud to be apart of this study and share my thoughts on the subject. I hope I've been helpful (see Appendix A).

Although each parent was involved in this study voluntarily, the desire to aid in this research surpassed mere participation.

CHAPTER FIVE: DISCUSSION

After a thorough review of related scholarship, and a detailed exploration of methodology and results, conclusions can be drawn. Researchers, scholars and practitioners have highlighted the differences in help-seeking behaviors among racial and ethnic minority communities. With African Americans in particular, researchers attribute some of these differences to a preference for seeking guidance and support from parents and guardians rather than professional mental health services (Levin, 1984). When unearthing the logic behind the mental health help-seeking behaviors of African Americans Hopson (2007) notes that culture, as a driving and impactful variable, shapes and governs social norms within the community. Merely working from a culture focused mindset can substantially increase access to and the quality of mental health services.

Exploration of Research Questions

When returning to the research questions, key conclusions can be drawn. RQ1 attempts to uncover the mental health perceptions and attitudes held by African American parents. There were no major indications of hostile attitudes towards mental health. A majority of the participants recognized mental illness and mental health services as vail, however did not register these concepts within their own lives. The parents seemed to distance themselves from the subject matter. These attitudes were best highlighted in the coded themes: surge in mental health awareness, misconceptions of mental health concerns, and trust vs. mistrust in mental health professionals/providers.

RQ2 expands the logic of RQ1 in relation to how these mental health attitudes affect how parents communicate mental health to their children. The results convey a passive approach in starting conversations about mental health. Participant 4 stated, “No, I never discussed it because I never came in contact with anyone I thought needed it. My parents weren’t in mental health so I never faced it” (see Appendix A). Similar remarks were repeated throughout the “unprepared for discussion” coded theme. The major conclusion from this question suggests a necessity for making mental health a family priority. The generational education gap theme emphasized the neglectful attitudes towards mental health, which has speculatively been passed down.

RQ3 positions the Black church as salient in the attitude formations of Black families. This question uncovers the role religious institutions play in framing mental health. Overall, the parents did not discuss the Black church specifically as much as the literature would predict. Participant 6 stated, “the church. Being I am not a big fan of medicine, you know I turn to the church for prayer” (see Appendix A). This specific declaration of the church being more credible than medical professionals coincides with current literature surrounding the active role of the Black church and mental health. However, in relation to the other participant responses, this was an outlier response suggesting the Black church as a potentially less influential factor than previously chronicled.

RQ4 explores tensions regarding parent perceptions of mental health and the effect those perceptions have on the healthcare decisions of their children. Based on the responses from the interviews, African American parents naturally have a strong presence

in the decision making of their child's healthcare. Congruent with Dutta and Basu (2008), topic avoidance seemed prevalent across the interviews. When mental health is not actively discussed with adolescents by their parents, they are less likely to feel empowered enough to be involved and take control of their healthcare (Mann, Hosman, Schaalma, & de Vries, 2004). Participant 10 was the only parent to address the necessity to empower their children:

As they start to get older, meaning 12-13 years old, you want to empower them.

So that if they make mistakes, you want them to learn from it. You want them to feel empowered to get it right (see Appendix A).

This research question aligns with the theme of African American parents being unprepared for discussions about mental health. Participant's 2, 3, 4, and 5 specifically mentioned they had never discussed mental health with their children, with Participant 5 noting:

I guess really no, it just never really came up. I didn't think any of my children had any mental health issues. None of my close family members ever had any mental health problems, so it just never really came up (see Appendix A).

The burden is placed on those with mental health concerns (in this case adolescents) to come forward in order to receive support. As the Health and Human Services Office of Minority Health (2008) argues, members of the African American community are often hesitant to accepting the probability of mental illness affecting their families. Participant 8 provides insight to this reluctance,

It's almost like cancer, we all know someone who has been affected by cancer; but until it happens in your family, you kind of dismiss it. And I think that is how it was viewed back in my day coming up. Once it happens to you it's like being the victim of a crime. You never understand a mugging until you've been mugged (see, Appendix A).

Analysis

The Black Church. The importance of the Black church has been documented in the four primary areas of communal medicine: primary care delivery, community mental health, health promotion and disease prevention, and health policy (Blank, Mahmood, Fox, & Guterbock, 2002). Black churches have been traditional safe places where African Americans historically have gone to for help. In reference to the influence of the Black Church on African American mental health perception, the data suggests a more passive role than previously thought. When coding for faith, most participants acknowledged religion as salient in perception formation. While scholars, like Koenig (2001); Harley (2005); Levin (1984) have argued religion as a more active role, this study suggests religion has minimal impact when actually seeking mental health services. Information regarding the religious denomination of the participant's churches was not recorded, future research should explore whether or not the role of the Black church within Black families fluctuates cross-denominationally.

Suicide awareness. A salient observation outside the scope of the interview questions, revealed unprompted acknowledgment of higher suicide rates. Participants 1,

5, and 8 utilized suicide as an example of mental health information. With respective responses:

“I think there is more awareness than there were before. There may have been a lot growing up, but you just weren’t aware of it. But you see the suicide rates among kids who are reaching out and not receiving help”

“When did I first hear them? I would say about in 2000, is when it really started coming out more about mental illness. I guess with like teen suicides. It just became more popular”

“I’ve definitely seen more support; I think maybe in the last five years, because of the increase in teen suicide. It may have always been there but people just didn’t hear about it” (Appendix A).

These responses directly correlate with Tavernise’s (2015) discovery of increased suicide rates. While Tavernise highlighted higher suicide rates amongst black children than their white counterparts it is unclear if the suicide rates mentioned by the parents, was a general observation or racially presumed. Regardless, the mere acknowledgement of increased suicide rates reveals a sobering reality within the African American community: knowing a problem exists, is not the same as proper recognition and action.

Education. Another important finding in this study not addressed in current scholarship is the desire to help educate and be educated about mental health by African Americans. While studies have suggested misconceptions of mental health by African Americans (NAMI, 2016; Hopson, 2007; Neighbors, 1984) few examined the desire to gain knowledge. All of the participants who had a positive or neutral position

surrounding mental health services admitted the gaps in their understanding, but seemed eager to learn more. Participants 1, 6, and 7 also commented on the importance of this research. With Participant 7 noting,

I think that this topic is really worthy of exploration. And I think that there needs to be more how they either...communicate concerns of mental health, how people communicate around the issue of mental health. And strategies for how to be more supportive in that, from a communication perspective (see Appendix A)

Findings such as these indicate a willingness to reexamine the stigma of mental health, from societal and intercultural perspectives.

Systems theory. Participant 6 discussed the sense of communal responsibility in raising and informing children. The presence of the “family structure” aligns with Harley’s (2005) assumptions of the communal disseminations of knowledge. Applying systems theory directly, Hill’s (1977) extension of this research supports four conclusions. The first conclusion, conceptualizations of a family’s “systemness”, is categorized by the systems ability to be relatively close; all participants in this study mentioned a positive and close relationship with their child/children. The second conclusion, conceptualizations of structure, like norms and beliefs, informs behavior. Participants 5 and 6 showed the most apprehensions to mental health services, subsequently both participants turned to religion before healthcare providers. Conclusion three, conceptualizations of goal orientation, is measured by the task performing abilities of the family. Participants expressed hesitation in starting discussions of mental health and seeking mental health services. The fourth conclusion, conceptualizations of orderly

sequences, is observable over a lifetime. The generational education gap of mental health and associated services—still affect families in present time. Systems theory explores the functionality of systems in relation to one another. The generational education gap of mental health and associated services still impact families in present time. Systems theory explores the functionality of systems in relation to one another. This data suggests that while Black family systems are still heavily connected with systems of the Black Church, the functionality of Black families is more independent, than previously suggested.

Communication privacy management theory. Petronio's (1991) CPM theory extrapolates the ways in which we balance and control the dissemination of our private information. Health information is sensitive (Petronio, Helft, & Child, 2013) and the addition of race and culture complicates the handling of this information (Robinson, 2012; Hopson, 2007). This sample supported these base assumptions, highlighting tensions surrounding topic avoidance and mental health erasure. Morgan (2011) identified *self-protection* and *relational protection* as salient variables in topic avoidance surrounding. Self-disclosure consists of constant negotiations in deciding what information to share, who to share information with, and who to trust as “co-owners” of private information (Petronio, & Dunham, 2008). Some parents expressed uncertainty with how they would handle discussions with their children, if they claimed mental health concerns: “What would I say?! “You want to talk about mental health?” That would be odd” (Participant 1, see Appendix A). While self-protection is a natural concern for the self-discloser, these interviews show the complexities of relational protection, as experienced by the parents. By controlling self-disclosure of a mental health status,

disclosers can stay in control of who knows what about their illness (Corrigan, & Lundin, 2001). As hypothetical new “co-owners” of adolescent self-disclosed information, African American parents in this study feared worsening the situation and potentially straining their relationships with their children.

Recommendation

The Banyan. The Banyan is a non-profit organization dedicated to combating mental health stigma in the Indian community while empowering Indian women with mental illnesses through services and support (The Banyan, 2005). Established in 1993, The Banyan has played an integral part in caring for people with mental illness in Chennai, Tamil Nadu.

Battered, bruised, brutally abused, both physically and sexually, ignored by everybody, eating out of garbage bins and with no place to call home. This was the situation of Chennai's homeless women with mental illness even just a decade ago. They were an invisible minority, and would have stayed invisible had it not been for two young women who put them firmly back on Chennai's social agenda (The Banyan, 2005)

Outlined in its history, The Banyan has sponsored projects which has changed the lives of over 5,000 people. By providing services to support them, the women of Chennai follow the path of recovery via four concepts: (1) *care by human touch*, (2) *treatment close to home*, (3) *assistance for the whole family*, and (4) *understanding*.

The Banyan should be viewed as a case study and recommendation for other ethnic minority groups. The mission of combating stigma specific to one culture, is

relatively new to mental health professionals (Thornicroft, Rose, & Kassam, 2007). These four core concepts of recovery can be cross-applied and specified for the Black community. Care with a human touch ensures effective treatment with a model which combines medication and rehabilitation (The Banyan, 2005). The idea behind this concept, argues for the acknowledgement of medical services and to see these services as natural, as human. Treatment close to home encourages those with mental illness and their support system (i.e. care takers, parents, guardians, etc.), to seek professional help by making the process easy and accessible. Assistance for the whole family relieves the resource burden of a mentally ill, physically and financially and to ensure effective care at home. This requires an active investment of mental health by the African American community. If more resources were available, and tailored to the specific needs of the community, then the burden of responsibility becomes a shared experience, rather than a lonesome tribulation (The Banyan, 2005; Corrigan, 2000). Finally, heightened understanding and awareness for change; by alerting communities, schools, government bodies, and other stakeholders to encourage policy changes against the legal and culturally perpetuated discrimination of the mentally ill opens a system which allows those with mental illness to live the lives of their choosing, with dignity and respect (The Banyan, 2005). This organization is a great example of how culturally specified treatments and support services can positively affect communities steeped in stigma. This paper recommends programs like The Banyan to be organized, tailored, and created by members of minority groups to fit the specific needs of each community. The saying goes “it takes a village to raise a child”, organizations like The Banyan take the first step in

educating parents and guardians; in an effort to increase visibility and protection for our communities.

Limitations

Focus on Church-Going Participants. This study looks at minority mental health through the focal point of the African American community. While Afrocentric perspectives are scarce in academia, the drawbacks with highlighting the Black perspective potentially misrepresent other ethnic minority populations. This paper emphasizes minority perspectives, the Black Church offers an interesting case study for examining mental health perceptions in African American parents. However, these conclusions may be non-applicable and less salient to other ethnic Black communities. Moreover, not all African Americans are religious or go to church, the work excludes African American perspectives from other religious and non-religious backgrounds. In the future, more efforts need to be taken to ensure wider representation of marginalized groups. It may be salient for future research to supplement the use of qualitative interviews with questionnaires, in order quantify the various cultural identities intersecting mental health among marginalized groups.

Data collection and sampling. A major limitation in this study reveals itself in the data collection process. While recruitment memos were sent to various churches in the area, on average, there was only 1 interested participant per church. Conclusions drawn from this sample size, are certainly not generalizable to the entire Black community. That being said, the interviews conducted showed a range of opinions and perspectives.

Participant drop-outs. While ten interviews are recorded and analyzed in this study, technically twelve interviews were conducted. A short time after the interview process, two different participants asked to be removed from the study sample. Because participation in this study was voluntary and anonymous, their responses were removed from the data set without question. Moreover, one potential participant cancelled their interview after initially agreeing to and scheduling an interview time. Motivations behind these decisions are unclear; however, this may inform the literature supported assertion of high topic avoidance surrounding sensitive subject matter (e.g. mental health) in the African American community.

Another limitation regarding the sample is the limitation of relying on self-reported data. It is not possible to know whether respondents provided honest responses, especially from those respondents who have or who know someone with a mental health concerns. As the literature suggests, honest discussions of mental health may be strained or filtered due to the stigma surrounding mental illness (Allen, 1997; Feldman, & Crandall, 2007; Anglin, Alberti, Link, Phelan, 2008; Kohinor, Stronks, & Haafskens, 2010). Mental illness is also an emotional and very sensitive subject, many people may not report experiences as they actually occurred. They may underestimate or overestimate these encounters. Thus, data can only be analyzed based on the recounts of those who participated in this research study; keeping in mind actual occurrences may vary. Future observational research could be conducted to help verify the self-reported data in this study.

Wording. Another limitation to arise during this study, came to light during the interviewing process where some questions were confusing because of wording. Because a majority of the participants interviewed happened to be above 56 years of age, discussion concepts were hidden and unclear. Although understanding was mutually agreed after clarification, the initial misunderstandings created a slight distance between the participant and the discussion. More specifically, complicated wording disrupted the rapport building throughout the interview; and thus, likely discouraged participants from sharing or expanding upon answers. Concepts like “mental health services” and “mental illness” are commonly used in modern society because of the increased visibility of mental health. In the past, these concepts were less well known (Neighbors, 1985), in the future, accessible research needs to consider the age range of potential participants, during every step of the interview process.

Absence of adolescent perspective. While the interviews from the parent participants help shine a light onto the views of mental health in the African American community, it is still unclear whether adolescents share the exact same beliefs as their parents. Because no adolescents were actually interviewed, it is impossible to truly know their thoughts and feelings about mental health. This limitation presented unique difficulties; children and adolescents are extremely difficult to research without ample time, patience, and resources. Moreover, the sensitive nature of mental health conversations was observable in the way parents talked about their children. Throughout the interviews there were seldom times where a parent attempted to speak on the views held by their child. The absence of adolescents from the study made it impossible to

determine if the views of parents were indeed related to, or correlated with, the mental health perceptions of their teenage children. As a result, the exploration of RQ2 should be viewed as preliminary and speculative.

Heuristic Dimensions

This study has several strengths in terms of its methodology and practical implications. One strength is the use of qualitative interviews to grasp and unearth the mental health perceptions of African American parents. This study also has many practical implications as it employs systems theory and CPM in relation to marginalized group effects on adolescent disclosure of mental illness. In addition to exploring qualitative methodology, reasoning, and responses to disclosure and mental health this study builds upon a limited body of research on the topic of disclosing mental health information in the Black community. In this case, it suggests a need for culturally-specific mental health treatments and discussions.

This study invites health communicators to attend to the effects of culture, bias, stigma, discrimination in how we frame mental health promotion. This study provides Black families interested in mental health research information on how to best analyze their approach, reaction, and response to someone with a mental health condition by pinpointing major reasons and tensions for disclosure with emphasis on the potential responses that may arise. A further more in-depth study may explore preferred responses to mental health disclosures.

Theoretical contribution. This study contributes to a heightened understanding of CPM theory, while reframing a core concept of the theory. Petronio (2010) classifies

“co-owners” as individuals to whom private information has been shared. The person who originally discloses the private information is tasked with setting boundaries and rules surrounding the handling of the private information, with the new co-owner. These rules can determine who else is allowed to know the information, how the information should be discussed in future conversations, and how the information affects the relationship with the discloser and co-owner. After this study was conducted one question was still unanswered by the current literature on CPM: what happens when the private information disclosed has permanent affects on the relationship with the co-owner?

Permanent co-ownership of information. When private or sensitive information is shared, co-owners are tasked with following the set boundaries as long as the information remains private/sensitive by the discloser (Petronio, 2010). For instance, if a person discloses they have an injured leg they would like to keep secret that information alone only affects this discloser and co-owner as long as the information remains private and/or active. Once the leg injury has recovered, that private information is less likely to have continuous effects on the relationship between the discloser and co-owner. However, if the leg injury was permanent, the disclosure of that information may affect the relationship long-term.

Similarly, the disclosure of a person’s mental health status produces a permanent co-ownership status of this shared information. Mental illness is traditionally met with terms of treatment rather than terms of cure. When a person admits to having mental illness or mental health concerns, they are essentially “coming out” about their mental

health status. Thus, co-owners are tasked with managing that sensitive information indefinitely, or when the discloser changes the boundaries surrounding that information.

This study offers “permanent co-ownership” as a way to reframe the responsibility of communication management. The American Academy of Experts in Traumatic Stress (2014) stress the importance of viewing mental health as a public health issues; this classification aims to reduce stigmatize on the individual with mental health concerns by highlighting communal responsibility. In short, we all hold some responsibility for our collective public health. As reviewed in this study, people tend to ignore mental illness and mental health when they believe it does not apply or affect them. Bernheim and Lehman (1983) argues, this trend of complacency and dissociation is even more prevalent amongst parents in relation to their own families. Permanent co-ownership rhetorically eases the burden off the discloser and argues for the co-owner to conceptualize the private information as though it were their own. This contribution challenges family members and co-owners to fully connect throughout the disclosure process.

Future research. Future directions for research should focus on the mediation between African American parents and their children, focused on creating an atmosphere where dialogue and open communication take precedent.

Initial hypothesis. The original second research question, *Does mental health promotion by African American parents influence mental health perception of African American adolescents?*, concentrated on the correlative relationship between parent mental health promotion and adolescent mental health perception. The intention behind

this hypothesis was to chronicle mental health perceptions across parents and their children. The generation-education gap theme proved salient in this study. This theme shows a gap in knowledge about mental health generation to generation. Participant 3 noted:

I guess I haven't really talked about it directly. Most my children probably know about more than I do. Because they were born in a different generation. What it all boils down to, Black people didn't get very much education in those days. Any person born in this world with no education, they know nothing (see Appendix A).

Similarly emphasized by Participants 2, 5, and 10, the lack of education in older generations has directly imprinted mental health misconceptions to their children. As previously cited, Participant 10 talked through the negative perceptions of mental health in the African American community, highlighting a communal response to delegitimize mental illness. However, Participant 10 continues,

It wasn't the norm. It was something that was always given an excuse: that person was just weak, or they needed to pray, or they just needed more faith. But I do know it exists, it is real, it is something that crosses all racial lines. It certainly is real; I have come to realize it is real. And if you think about human nature, it's part of who we are (see Appendix A).

This parent confronted the mental health perceptions learned at a young age and adapted them over time. This suggests knowledge and accessible information can penetrate generational preconceptions. Future research needs to explore this hypothesis further in

order to confirm the existence of this relationship. As knowledge about mental health grows and is disseminated throughout society mental illness stigma decreases (Corrigan, 2000).

In addition, future research should factor severity of mental illness in relation to race, and self-disclosure practices. Type of illness could be used to see if there are differences in how one decides to self-disclose based upon the type of diagnosis. For example, a future study could compare various self-disclosure patterns of those who have depression, versus those with borderline personality disorder.

Finally, further research needs to explore the discrimination of minorities in the mental health industry. Latino communities face discrimination in terms of access (Vega, & Lopez, 2001); Asian communities face discrimination when opting to help the mentally ill (Ng, 1997); Indian communities face discrimination seeking mental health services (Shidhaye, & Kermode, 2013); and African American communities face discrimination in diagnoses and treatment (Harley, 2005). The exploration of minority mental health services is still lacking in terms of culturally sensitivity and equal access. Future scholarship needs to answer these questions: How do we best maximize our mental health services for minority communities? How can medical professionals, develop trust with communities who garner high levels of mistrust with the healthcare industry? What steps should minority communities take to better educate members about mental health and services while combating mental health stigma? How can parents best promote mental health to their children?

Growing up, a common phrase passed around my family and Church members, my first introduction to mental health, was “Black people don’t get depressed, we get the blues.” The trivialization of mental health in the African American community has been an overlooked issue for decades. Within recent years, mental health visibility has substantially expanded in mainstream media and society (NAMI, 2016); however, the visibility of African Americans within societal conversations of mental health remains low. This allows African Americans to disassociate themselves from mental illness and mental health narratives. It is imperative for African Americans to be more present in national discussions of mental health, in order to improve community-tailored mental health services and promotion. After examining current literature, exploring various frameworks, and drawing critical conclusions, the roles of mental health, parents, and culture have been shown. The disclosure process is critical in mental health research for the simple fact that research cannot be furthered without the acknowledgement of a person’s mental health status. It is the access to such in-depth and personal research which advances or halts society’s perception of mental health. Discrimination against minority populations maintains a constant and sobering reality in the healthcare industry. Effective promotion and dissemination of mental health services and information is imperative to the effective treatment of mental illness in minority communities.

APPENDIX A

Abbreviations

“R”-Researcher

“P”-Participant

Code Colors

-SURGE IN MENTAL HEALTH AWARENESS: Purple

-GENERATIONAL EDUCATION GAP: Blue

-PARENT-CHILD RELATIONAL SHIFT: Grey

-MISCONCEPTIONS OF MENTAL HEALTH CONCERNS: Red

-TRUST VS. MISTRUST IN MENTAL HEALTH PROFESSIONALS/PROVIDERS: Pink

-UNPREPARED FOR DISCUSSION: Green

-RATIONALE BY FAITH: Yellow

-IMPORTANCE OF STUDY: Brown

Interview Transcriptions

Participant 1

R: Hello and thank you for doing this interview. So my first question is: What does parenting or being a parent mean to you?

P: Providing support and guidance to my children so that they can survive in a world that is not always so kind.

R: Alright, so for my second question, is: How would you identify your relationship with your child? Why?

P: Its up and down—its up when we all agree and its down when I have a differing opinion.

R: Alright, so do you think it is a constant thing or something that you have to develop?

P: Hmm, I wouldn't say its constant—it varies by topic.

R: Alright, so for my third question: How have you maintained this relationship status?

P: By keeping close contact with my children, whether they like it or not. I like to communicate regularly with them.

R: Is that something that's important to you?

P: Yes.

R: Can you explain that a little more for me?

P: I think because of the way the world is now, I always want to make sure my children are ok at all times.

R: A completely natural response. So number four: What is your current view/perception of mental health? Has this changed overtime?

P: Okay I have to think about that...my view of mental health is how a person handles day to day struggles—little or major. And if someone constantly is struggling with day to day situations, then they may need some help.

R: Have you always believed this?

P: I have become more aware of this over time because of my profession. In my profession as an educator—I recently talked with one of my teachers who I had noticed...had a lot of absences. I had to sit her down and just said: “I don't know what's going on, but I've noticed a pattern of things going on. Is there anything I

can do to help? I don't want to get in your personal business, but..." And comes to find out she did. Have problems, and had to check herself into a mental institution.

R: And you found that after that conversation, it helped her?

P: Yes, I actually got an email from her which just said "thank you."

R: Alright, well would you say that was a turning point in how you viewed mental health?

P: No I would say that over time, I have felt when someone is struggling. Not to approach them in a confrontational way. Me being upset, is not going to make them feel better.

R: Ok, so number five: Can you recall your first introduction to mental health or illnesses?

P: Again, going back on my profession as an educator. I was a special education teacher before I became an administrator. I work with children that have mental health issues. Eventually the school system just didn't have enough resources to assist them—they just weren't getting enough help with what we had. So yeah, I would say that was my first introduction to mental health.

R: Speaking on your career, do you see a lot of support from parent with children who have mental health concerns.

P: I've definitely seen more support; I think maybe in the last five years, because of the increase in teen suicide. It may have always been there but people just didn't hear about it. Mental health organizations are reaching out to work

together—otherwise, parents would just probably have to go to try to seek help. If they couldn't afford it, they would dismiss it. Had to realize it's not something that will go away. It needs to be addressed.

R: Definitely, for number six: Has anyone influenced your beliefs about mental health? If so, how? If not, where do you derive your current understandings?

P: I think my reading have made me more aware and to pay better attention. I would never want a student or anyone I know to take their life, because they didn't have any resources to help them.

R: Hmm, and these are readings you sought out?

P: I read everyday.

R: Oh, okay

P: I sign up for educational magazine subscriptions and materials. You see more and more information about helping students. Bullying is huge—its always been there but now you have cyber bullying. And other tools to help kids be mean to one another. Its about recognizing that kinda of stuff and the signs. Trying to do what you can to decrease it.

R: Thank you for that, so Let's talk about mental health and your family. Have you ever discussed mental health with your family? If so, how did you go about doing so? If not, is there a reason?

P: Umm, I have not discussed it enough with my family—because I didn't want to put anyone in a corner. If they want to discuss it they could come find me. But no, I haven't have a full blown discussion about it.

R: You said you wanted someone to feel comfortable coming to you?

P: mmhmm

R: Was that a thing you were just putting out there

P: What would I say?! “You want to talk about mental health?” That would be odd.

R: Alright, and for number eight: How would you react to your children claiming they had a mental health concerns? Is there a method or thought process you would employ?

P: Well first, I would be concerned. And then second, I would try to get them whatever assistance they might need.

R: Alright, have you ever turned to any non-medical institutions, for medical concerns (i.e. Church, community centers, etc.)?

P: No

R: And then finally, are there any final thoughts about anything previously discussed? Comments?

P: About what?

R: Just the topics we have been talking about

P: Nope.

R: Alright, thank you so much for doing this study.

Participant 2

R: Hello and thank you for doing this interview. So I have ten questions for you and I'll start with my first question is: What does parenting/being a parent mean to you?

P: Look, can I put it in my own words. I may not be able to give you the big words.

R: That's perfectly fine, I want to hear your opinions.

P: Being a parent means being there for your kids at all time. And guiding them in the way they need to go. And ofcourse that means spiritually, as well as physically—mentally. Hmm, and its...its a job that you don't get paid for. But you get the results in how they turn out. What else?

R: Well my second question: How would you identify your relationship with your child? Why?

P: Uhh, I identify my relationship with my children as being their Mother as well as their friend.

R: Hmm

P: Uhh, we have that closeness, you know? We are there for each other, in whatever the cases may be. You know if they need any advice. If they need any help, in whatever way I can help. You just gonna always be there for them, even though they grown.

R: Definitely, that kinda leads into my third question: How have you maintained this relationship status?

P: How what?

R: How have you maintained this closeness and this friendship?

P: Umm, I don't get the other words your saying?

R: How do you stay friends with your children?

P: Oh! Oh oh...haha, well Its just a natural thing. It always has been. Umm, how? How? How? How?

R: Haha

P: Well a parent is someone you can lean on for advice and help. And it's a two-way thing—because your parents need your help and advice sometimes. And just be there for them. A parent and a friend. And, umm, the difference in a parental friend is you're not going to agree with them if they're wrong. You help them over come that. A friend might agree with you in a way and watch you go up in smoke, so to speak. Not intentionally—they just don't have that bond you have with your children.

R: So my fourth question is a little bit of a departure: What is your current view/perception of mental health? Has this changed overtime?

P: Mental health...hmm...let me see. That's an area I haven't really dealt with. Are you saying if I know someone who has...that kind of situation?

R: No, I am just asking about your feelings in general about it.

P: Mental health is very important. I think it is more important than any kind of health. Because if you are not mentally prepared, everything else falls apart. I think mental health is very important.

R: So my fifth question is: Can you recall your first introduction to mental health or illnesses?

P: Not really. Uhh, I have uhh. You know back in the olden days—which would be my younger days. I didn't know that much about it, I would hear, to use an old expression—they lost their mind or something like that. I didn't know too much about it but mental health is very important. Because people get too much put upon them in life and I think that's what causes it. The mental health problems. Unsolved issues can cause mental health—and sometimes what you eat.

R: Hmm, so you mentioned that it wasn't really talked about in the old days—could you talk a little more about that

P: You dealing with Black people—they probably didn't know anything about it. Their mind is gone or something like that—they didn't know that much. The education definitely wasn't there. We sure didn't learn about it in school—about the mentals. And ofcourse, I'm looking at people born in the 20s and 30s. That was my family. It wasn't much education, and a lot of them didn't even go to school. Parents couldn't always afford it and no body made them go. You didn't know about that did you?

R: I didn't actually

P: My mother didn't go farther than 7th grade. Nobody told them they had to go—parents didn't get on them about that.

R: So, that transitions to one of my questions: Let's talk about mental health and your family. Have you ever discussed mental health with your family? If so, how did you go about doing so? If not, is there a reason?

P: I guess I haven't really talked about it directly. Most my children probably know bout more than I do. Because they were born in a different generation. What it all boils down to—Black people didn't get very much education in those days. Any person born in this world with no education, they know nothing.

R: How would you react to your children claiming they had a mental health concerns? Is there a method or thought process you would employ?

P: Yeah, I definitely need to go to a specialist to get it worked on. Uhh, ofcourse I would do whatever I could—but I am not a doctor.

R: So, have you ever turned to any non-medical institutions, for medical concerns (i.e. Church, community centers, etc.)?

P: No, not really. As far as mental health is concerned. I pass on whatever I hear

R: and my final question: do you have any final thoughts about anything previously discussed? Comments?

P: Basically everything was my common knowledge except the mental health thing.

R: Alright, well thank you so much for doing this study.

Participant 3

R: Hello and thank you for doing this interview. So my first question is: What does parenting/being a parent mean to you?

P: Being a parent mean to me, that you're suppose to teach them right and wrong.

Take care of their need, within some degree. And teach them how to be an adult.

How that sound?

R: Sounds good to me, so for number two: How would you identify your relationship with your child? Why?

P: Uhh, I identify my life with her because she is a good daughter. I love her. She just thinks she can buy me anything she can afford. She is very mannerable. I just love her

R: That leads into my third question: How have you maintained this relationship status?

P: With whom?

R: With your daughter.

P: She was just here this weekend, and you can't say I have to do thus and so. Because she will readily do it. And I don't want her to, because she works so hard. So I try to only ask for the things I need.

R: Mmhmm, so my fourth question is a little bit of a departure: What is your current view/perception of mental health? Has this changed overtime?

P: My mental health seems to be pretty good for a woman who is 92.

R: How do you feel about mental health in general?

P: Its very important! The important thing is to take care of yourself while you're young and then when you get older, it will let you know what you've done—

when you's was a young person. Not drinking and smoking, because that's bad for your health.

R: Mmhmm, has this opinion changed over time?

P: Nope, never changes.

R: So my fifth question is: Can you recall your first introduction to mental health or illnesses?

P: Well I work hard. But I can't recall.

R: Alrgiht, Has anyone influenced your beliefs about mental health? If so, how? If not, where do you derive your current understandings?

P: No, I never had that conversation.

R: Well, is there a reason why you didn't have a conversation?

P: No, it just never met the people who would bring it up.

R: So my seventh question is: Have you ever discussed mental health with your family?

P: Yeah, I have.

R: And how did that go?

P: They would say "yeah, well you're not a doctor, but I will take it under consideration."

R: Alright so, have you ever turned to any non-medical institutions, for medical concerns (i.e. Church, community centers, etc.)?

P: Have I ever gone to one?

R: For medical purposes.

P: Now, I haven't really turned to the Church for anything like that.

R: Any final thoughts about anything previously discussed? Comments?

P: No, but I think that this was just very interesting.

R: Alright, well thank you so much for doing this study.

Participant 4

R: Hello and thank you for doing this interview. So my first question is: What does parenting/being a parent mean to you?

P: Well its quite a responsibility. It means taking care of your children and trying to show them in the right direction. And I was guided when I was young. You want more?

R: My second question is: How would you identify your relationship with your child? Why?

P: Well first thing I would say is that I love them—and I try to live the life that I would want them to live. And, I try to guide them in the right direction—because they're young and not mature enough to live the life that I have lived.

R: So How have you maintained this relationship status?

P: With love and understanding.

R: So my fourth question is a bit of a departure: What is your current view/perception of mental health? Has this changed overtime?

P: Well I would say at this point in time, my mental health is good for my age. I took care of myself when I was young and that made me be in the health I am today—by not drinking and smoking and all that.

R: Do you think mental health is important?

P: Very important. Very important.

R: Can you recall your first introduction to mental health or illnesses? Have you seen it in someone?

P: No, I can't actually recall anyone with mental health.

R: Alright, so my sixth question is: Has anyone influenced your beliefs about mental health? If so, how? If not, where do you derive your current understandings?

P: Yes, by my parent leading me in the right direction—it gave me an incentive to live in mental health well.

R: Let's talk about mental health and your family. Have you ever discussed mental health with your family? If so, how did you go about doing so? If not, is there a reason?

P: No, I never discussed it because I never came in contact with anyone I thought needed it. My parents weren't in mental health so I never faced it.

R: How would you react to your children claiming they had a mental health concerns? Is there a method or thought process you would employ?

P: I would try to give them help—professional help—as well as what I could give on the individualistic level.

R: Alright...

P: Do you need more?

R: Oh no, I'm sorry—I am just jotting down a few notes...So my ninth question is: Have you ever turned to any non-medical institutions, for medical concerns (i.e. Church, community centers, etc.)?

P: No, I never have—because I never gotten to the point where I needed professional help. Or spiritual help.

R: So you mentioned spiritual help, do you think that has anything to do with mental health?

P: Yes, I do, I think all things is controlled by the lord. And perhaps through spiritual help—he will answer your prayers. And so far it has—it helps me on the day to day things.

R: Mmhhh, Alright—and then my tenth question is: do you have any final thoughts about anything previously discussed? Comments?

P: Not more than anything I had to talk to you about. I pray for your success in life through spirituality and prayer. Going to church and listening to ministers...

R: Alright, well thank you so much for doing this study.

Participant 5

R: Hello and thank you for doing this interview. So my first question is: What does parenting/being a parent mean to you?

P: Wow...well, parenting is a gift from God. It's one of God's blessings—giving us children. Its just a blessing. Its just showing God's love for us—by giving us children.

R: My second question is: How would you identify your relationship with your child? Why?

P: As adults?

R: Anytime really.

P: Well right now its wonderful. We have wonderful relationship now. In the beginning—well I'd say the teenage years, it wasn't. You know you were a parent first. And children don't seem to like the structure you have to give them; but then they start to appreciate it later in life. That's when your relationship grows stronger—because they can identify what you've been teaching them all these years. They learn to appreciate it.

R: So that leads into my third question: How have you maintained this relationship status?

P: Well.... hmm...so how you maintain your relationship with your children now?

R: Well yes, so how have you maintained this “wonderful” relationship you described earlier?

P: Well, for my child that has children of his own—he will come to me for advice on how to raise his own children. You're closer because when he did listen growing up, so now he just seeks the advice from you now. And then, with the child that doesn't have children—just constant communication. I know I call her all the time. I can be more friends with them now, because I don't have to be so stern with them now.

R: So what is your current view/perception of mental health? Has this changed overtime?

P: Oh...hmm...hmm, I don't really know how to answer that. My current view on mental health?

R: Yes.

P: You talking about these issues that people have nowadays

R: Just about your thoughts in general about the topic—there is not specific answer I am looking for.

P: Hmmm, I don't know—that's kind of a tough one.

R: Why is it tough?

P: Because some things they consider mental health now—wasn't really mental health when we were growing up. Things now seem to blame things on mental heal, I guess, than what we use to consider normal parenting. Let me see if I can break it down better. Like you would use ADHD, different things like that.

R: Mmhmm.

P: We had those things back then, growing up—but they didn't control it with medication. So when they have problems now, they blame it on mental health. Or ADHD, they have these different illnesses now. Which they had back then, but they had so much more family structure back then. You know like the community raises the children—they were not treated as mental health things. I'm not sure if that answers your question?

R: Yes, it totally does.

P: Well yeah, I think they use medication now to control things and issues.

R: Definitely, that leads into my fifth question: Can you recall your first introduction to mental health or illnesses? When did you first start hearing these terms?

P: Uhh...hmmm. When did I first hear them? I would say about in 2000—is when it really started coming out more about mental illness. I guess with like teen suicides. It just became more popular. I guess its because I drive the bus and I've been working with children since '94. You didn't really hear much about it—but you hear more about it now. I guess since 2000.

R: Alright, well has anyone influenced your beliefs about mental health? If so, how? If not, where do you derive your current understandings?

P: Well, uh...well like I said, working in the school system—you, see it a lot now. You know, anything...there's a reason for everything now. I don't think anyone influenced it, no.

R: Let's talk about mental health and your family. Have you ever discussed mental health with your family? If so, how did you go about doing so? If not, is there a reason?

P: No, actually I have not had to really discuss that with my family—no.

R: Is there a reason why?

P: I guess really no—it just never really came up. I didn't think any of my children had any mental health issues. None of my close family members ever had any mental health problems—so it just never really came up.

R: Alright, so my eighth question: How would you react to your children claiming they had a mental health concerns? Is there a method or thought process you would employ?

P: Well I guess I would ask the reason why they felt they had mental health issues—and yes I would seek help. If they did have it. I would find out why they think they have an issue. And find out if it's really an issue or another thing, you know. We would definitely have to seek professional help if I felt that had—well actually, even if they felt they had a mental illness. So yes, we would definitely have to seek professional help.

R: So have you ever turned to any non-medical institutions, for medical concerns (i.e. Church, community centers, etc.)?

P: Have I ever? Well I've turned to family members...and yes church members too.

R: And my tenth question is: do you have any final thoughts about anything previously discussed? Comments?

P: Well let me see...what exactly are you doing with this study.

R: Oh, the study is just looking at the ideas and perceptions of mental health amongst parents in the Black community

P: Oh...well I really don't see mental health problems in the Black community. I don't think? Without being judgmental, I don't really see it in the African American community as much as is other races

R: Alright, well thank you so much for doing this interview.

Participant 6

R: Hello and thank you for doing this interview. So my first question is: What does parenting/being a parent mean to you?

P: Uhh, it means responsibility man. For me it's a blessing, I know a lot of people can't have children. But its an amazing responsibility. And it's a joy—its hectic at times, but I wouldn't change my kids for the world.

R: That leads into my second question: How would you identify your relationship with your child? Why?

P: I have a good relationship with my kids—just because I interact with them a lot. My daughter is only 11 months—so not much to talk about there. And my son—well I'm stern on him, but I'm also his best friend. He always tells me everything.

R: Nice, and how have you maintained this relationship status? I know you mentioned they were young, so there is not that much time—but out of the time you have had?

P: Umm, take advantage of the time that I got with them. I work a lot, so when I'm not I try to really interact with them—see what's going on and just listening to him. Playing games, reading to him and stuff like that.

R: So my fourth question is a little bit of a departure: What is your current view/perception of mental health? Has this changed overtime?

P: What part of mental health?

R: Just the idea of it overall—you can specify or broaden it how you wish.

P: I mean... I think its very important—the mental state of the children? Or?

R: In general.

P: Umm, yeah I think it's a major problem. I think it is misdiagnosed a lot.

R: Talk about that a little bit.

P: Alright, so you know well people say its mental health as usual—mental issues.

A lot of that, I don't feel is so much mental—more emotional. How they were

brought up, if something bad happened to them. I don't think that someone is

mentally unstable, just because they think differently. I think part of that now, is

the way they were raised—or some kind of event that happened to them. When

you get to the medical part of it—I think a lot of the misdiagnoses comes from

Big Pharma, because you know they get kickbacks and all that. A lot of people

get diagnosed and put on all this medication—and that's all about money. For me,

that alters the way they behave. Whether its to make them calm down, I think

they're doping them up and most of it is just; to me, more so based off of Big

pharmaceutical companies making money.

R: Alright, can you recall your first introduction to mental health or illnesses?

P: Hmm...well I mean, just in the past few years—before I didn't give it much

thought. Before I was like—take ADHD—people would say its mental problems,

but it could just be something going on at home. Things that makes kids act

strange—traumatic events and what not. I would say in the last three years—

because you hear a lot more about it. Umm, and you see all of these. It seems like

every time something happens they blame it on mental health. You know mass

shootings and stuff they blame on mental health. I would say you hear about it way more now. Probably the last 3 or 4 years is when I started to pay attention. I mean you hear about it all the time growing up—but I never gave it any thought.

R: Has anyone influenced your beliefs about mental health? If so, how? If not, where do you derive your current understandings?

P: Hmm, yes. And just with information on how its misdiagnosed. Again like I said, I think its a lot to do with big pharmaceutical companies. I don't know, I don't want to get too deep into it. I would say, just the facts that have been presented about mental health—and its misdiagnoses

R: Let's put this all together a little bit, with mental health and your family. Have you ever discussed mental health with your family? If so, how did you go about doing so? If not, is there a reason?

P: No—I haven't really had a need to.

R: How would you react to your children claiming they had a mental health concerns? Is there a method or thought process you would employ?

P: Umm, I can't really say there is a method. I would just have to see it present itself and then react. Again, it's not something I really thought about—as far as my children. But I will say I would take them to see a specialist—but I wouldn't just go off of what that specialist said. I would definitely have to get multiple opinions. If there was an issue, I would try everything else, before I try medicine. I would definitely do some research on it.

R: Alright, have you ever turned to any non-medical institutions, for medical concerns (i.e. Church, community centers, etc.)?

P: You said non-medical places for medical?

R: Yes.

P: Umm, yes. I would say the Church. Being I am not a big fan of medicine—you know I turn to the church for prayer. Other than that, that's about it.

R: Alright, do you have any final thoughts about anything previously discussed? Comments?

P: Nah, I think that pretty much it. I don't know, it's a lot. You know with ADHD they say they don't have the mental capability be learning. All of that type of stuff—putting kids in special ed, when its really just for a kickback. And how a lot of schools got busted for doing that—you know some schools get \$15,000 per child that is in special ed. And they were using the money to fund sports teams and stuff. But it was predominately in your, where you have predominately Black students. There's just a lot of crazy stuff happening, man.

R: Yeah definitely—alright, well thank you so much for doing this study.

Participant 7

R: Hello and thank you for doing this interview. So my first question is: What does parenting/being a parent mean to you?

P: Parenting and being a parent means to be responsible for your child's well being. Provide food and clothing and safety—and in there belongs education and

opportunity for advancement and learning. You know providing and being responsible for those things they need for development.

R: Alright, my second question is: How would you identify your relationship with your child? Why?

P: Haha, so I have a son who is college age now—undergraduate—and a high school daughter. What I've realized is that relationships vary. With my son it was more—I think control was an issue. He wasn't a bad kid, but I think most kids struggle with control and to be told what to do. Once he went to college, he realized how important it is and appreciates it now. I'm going through the same kind of thing with my daughter now—just wanting to be very independent. But, starting to realize that independence means responsibilities as well. And that you can't pick and choose when you want to be grown. My relationship has been good for the most part and very interesting and rewarding—seeing them grow from teenagers to young adults. Watching their values and world views change.

R: Nice, so that leads into my third question: How have you maintained this relationship status?

P: Consistence, just being who I am. Always reinforcing the fact that I am doing it because I love you, I respect you, and I want the best for you. And umm, if in fact I do something or say something that doesn't align with those goals. I'm not too big to go back and apologize and say "hey look, I was upset" or "maybe I could have been a little more lenient in this regard." But again, everything that I am doing is to help them become adults—in a safe and productive way. So

consistence, being who I am and maintaining the values—not wavering so much that I confuse my kids by speaking one thing and doing another. So just staying consistent.

R: A slight departure on my fourth question: But what is your current view/perception of mental health? Has this changed overtime?

P: Mental health—wow—it is a powerful aid. It is a much, I think it is underexplored in terms of family dynamics. I think people vary in terms of mental health and mental abilities—and, I am beginning to understand that, the stigma associated with mental health for so long; has impeded the progress of many families—in ways we are just starting to learn about.

R: Has this changed overtime?

P: It has changed. It has changed, in knowing so many different people and seeing that people have different personalities—different levels of patience, different values. And I think that—from my personal experience—mental health was looked at as a negative. If a person had needed or took advantage of some tool or some professional guidance for mental health—it was seen as a weakness. Umm, but now I am understanding—to have support about one's mental health, is a valuable attribute. Perhaps more of us would benefit from that type of support.

R: Can you recall your first introduction to mental health or illnesses?

P: Umm, so personally it would have been through a family member—who had some mental health challenges in later stages of life. And so once I saw that unfold, I was personally introduced to it in way I previously hadn't. And it really

impacted the family, to the extent—family member had to...uh, a family was split do to the impact of one's mental health. Then later, in terms of academics, I had a student who explored mental health. Then I got to read the research and watch someone—essentially write a dissertation, having to do with mental health and well-being.

R: For my sixth question: Has anyone influenced your beliefs about mental health? If so, how? If not, where do you derive your current understandings?

P: Umm, again the influences and the experiences I have had are twofold: One, was personal—you know, being a member of a family. But I think of in terms of academia—a former student led me to some literature that opened my eyes to the challenges surrounding mental health. In particular, to Black and African American culture.

R: Have you ever discussed mental health with your family? If so, how did you go about doing so? If not, is there a reason?

P: We have had—I wouldn't say a formal discussion—but I have often wondered the influence of a counselor or counseling session. Raising teenagers, you never really know if they're on the right track. So I have considered bringing in someone who wasn't a family member or a parent—to see if that would benefit my children. And umm, I didn't initiate it—but I encourage my children to communicate whether or not they want that option. And if I can support it, I will.

R: So that leads into: How would you react to your children claiming they had a mental health concerns? Is there a method or thought process you would employ?

P: No, at this point it would be more about having them safe and healthy. So if seeking support, help, guidance, some professional intervention—that's what's important. That's most important. Then only thing that I would hope, is that my children—my wife and immediate family—would be willing to share with me what they are going through, so I could support them. I mean, you don't have to tell me everything—but let me know if you have concerns, and allow me to at least, acknowledge the fact that I may need to change my behavior or thinking, based on what you're going through. Invisible illness or invisible disabilities, or invisible challenges are sometimes—I think made worse, when people's ignorance gets in the way. And you don't allow them to support you, work with you—especially, as I mentioned with Black and African American culture. We tend to have a stigma anyway—and then there is often times the suggestion, that if you take it to God or take it to Church, then it will be fixed. Take it to a pastor, even. Umm, my father is a psychologist and he says one of the biggest challenges he has is, you know people assuming the pastor can make things ok—when, you know, the pastor isn't necessarily trained in counseling. At least towards mental health. You know, so we some times mistakenly think that we can find salvation, or find—uh, a solution. In places other than mental health professionals.

R: Which, directly brings up my next questions: Have you ever turned to any non-medical institutions, for medical concerns (i.e. Church, community centers, etc.)?

P: Personally?

R: Yes

P: No, I haven't

R: And my last one is: Any final thoughts about anything previously discussed?

Comments?

P: I think that this topic, is really worthy of exploration. And I think that there needs to be more how they either...communicate concerns of mental health—how people communicate around the issue of mental health. And strategies for how to be more supportive in that—from a communication perspective.

R: Alright, well thank you

P: Is that it?

R: That's all I got. Thank you so much for doing this study.

Participant 8

R: Hello and thank you for doing this interview. So my first question is: What does parenting/being a parent mean to you?

P: Uh Hello, thank you for inviting me, I appreciate it. I think parenting to me is you know watching a young person grow from a little bitty seed—in a sense—to this unbelievable human being. It's very emotional watching the process and being apart of that. Kinda what it means to me.

R: How would you identify your relationship with your child? Why?

P: Umm, I think my relationship with my children has been very rewarding to me. It gave me something I didn't experience growing up—because I come from a single parent family. I didn't have a dad growing up—so having a child, being there for the child, and seeing them grow up. It was an experience that was

different. It was kinda like me being a child again and being able to do the things I wanted to do with my father—and yet, being there for my children. It's almost indescribable.

R: How have you maintained this relationship status?

P: I have two adult children now, out on their own making their own life. But we stay in constant contact. It is very rewarding and humbling to see them go out into the world. Your whole life you've been their protector and now you go out and see them blossom into adults—doing things without your help.

R: What is your current view/perception of mental health? Has this changed overtime?

P: Mental health...it's kinda hard to define, I feel, because the way mental health was dealt with when I grew up. It is totally different now. Now, it's more medication and stuff like that, more than there used to be. I think there is more awareness than there was before. There may have been a lot growing up, but you just weren't aware of it. But you see the suicide rates among kids who are reaching out and not receiving help. Kids feel like they don't have a place to go. It's very hard to be a parent now, because if you don't have that communication with your child—and you don't see or notice the symptoms, it's very hard to differentiate.

R: And has your view of mental health changed over time?

P: Absolutely, I have had friends that have lost children because of this disease. And it's one of the worst things in the world, to loss a child and you can't do anything to help them.

R: Can you recall your first introduction to mental health or illnesses?

P: Um, maybe not the first. Because like I said, I knew it was around. We had been around it, so to speak. It wasn't personal or real close. I mean I've seen it before in some of the families I've been around. And you know, you just don't, I don't know if you block it out? It just wasn't personal—out of sight out of mind. People tend to don't view things that don't directly affect them. And I might have fallen victim to that myself. Not having someone directly affected by it, you kinda shuffle it under the carpet. People made wise cracks and didn't take it as serious as they could have. It's almost like cancer—we all know someone who has been affected by cancer; but until it happens in your family, you kind of dismiss it. And I think that is how it was viewed back in my day coming up. Once it happens to you—its like being the victim of a crime. You never understand a mugging until you've been mugged.

R: Has anyone influenced your beliefs about mental health? If so, how? If not, where do you derive your current understandings?

P: I've seen what this disease does to family and over time. And I've talked about—what it meant to me then vs. what it means to me now. As you get older, you are more aware of things that happen in your life. So I don't know if that answers your question or not, but that's kind of how I feel about it

R: Let's talk about mental health and your family. Have you ever discussed mental health with your family? If so, how did you go about doing so? If not, is there a reason?

P: I think its certain point and time—yea, you do discuss things like this. It comes down to, um, whether you know people in your family who might have some—and I've had people in my family who have over the years have bouts with mental health. You talk about it amongst each other; someone when you know, or who you grew up with or something like that—that have these issues—you really don't talk that much to the person. You want to show support, but you don't want to pry but if that person wants to come forward and address these concerns—of course you're gonna be sympathetic to their situation and try to understand where this person is coming from. But it's almost like a state of helplessness, because you're not a trained professional to deal with this—so there's not a whole lot you can do.

You don't want to irritate the person, or look at the person in a certain way and make them feel like something is wrong with them, when there is really not.

You're almost in a helpless state, where you don't know what to do for the person. I've been through some anxieties myself, and I've had to calm myself down. But I didn't need any kind of medication or through counseling or anything like that. And I use to have panic attacks, where it felt like the whole world was crashing in on me—but then I kinda realized, this is me doing this to myself. And I managed to somehow correct that—and became a calmer person. I did that by

understanding how to deal with my emotions, and how not to let the outside world affect me.

R: How would you react to your children claiming they had a mental health concerns? Is there a method or thought process you would employ?

P: Well, I mean—me, I've always felt that I am in control of my own destiny. I don't know how I would convey that to my child, that he or she would be in control of their own destiny. That would be a difficult thing to do. It depends how well they trust you as a parent. I've seen were kids seem to trust outside sources more than their parents. That's just a normal thing—because I remember at some point in my life I was the same way. So it is hard for a parent to get through to a child that they are there for them no matter what—even when it feels like the whole world is coming down on them. The parent can't always protect the child, so you just have to do the best you can—and let them know you are there for them no matter what.

R: Have you ever turned to any non-medical institutions, for medical concerns (i.e. Church, community centers, etc.)?

P: I haven't personally, no.

R: Any final thoughts about anything previously discussed? Comments?

P: Umm, I am not really sure. I think the subject is out there more so than what it has been in the past. You know you hear about teens committing suicide and you know, it leaves the parent in disarray. They are just devastated and they really don't understand. There's a lot of crazy things going on in the world, and I just

think there needs to be more honest communication between parent and child. So they can work things out, without having to take drastic measures. This world has a whole lot to offer, if you just go about it the correct way. Sometimes people don't deal with things for whatever reason—and I don't know how you bridge that gap?

R: Alright, well thank you so much for doing this study.

P: Absolutely.

Participant 9

R: Hello and thank you for doing this interview. So my first question is: What does parenting/being a parent mean to you?

P: Parenting to me, is not just having children. And you've heard the expression, "they grow like weeds." And you really have to mold them and shape them and spend lots of time teaching them—morals and goals. And things that are more important than money. That what parenting means to me. First of all, wanting children and not just having them—but planning for them.

R: How would you identify your relationship with your child? Why?

P: And you know, **God is so good and I am so fortunate**—because **I can truly say, and you can ask any one of my children. And whether I was or not, they will say that I was a great mom. And I truly thought I was a pretty good mom myself.** I spent lots of time with them. I remember years and years ago. Lets say they were 5—no wait, even younger than that; they were about 3 and 4, and they had just gotten off preschool and 1st grade. I came home from work, my husband was out

of town and I told them: “Mommy just needs 30 minutes to herself and then she’ll come out and do whatever you’d like.” It was then I had a revelation—I spend all of my time taking care of everyone else’s children and giving them the best. Then I get home and wonder—who is giving my children the best? I began to treat my children like I would my neighbor’s children. And that means going out of my way even when I didn’t feel like it. So ever sense then, whenever I came home I treated my kids with bounce and joy and energy. And then eventually, I didn’t have to pretend and that is who I was with them.

R: How have you maintained this relationship status?

P: Well after you secure that status—what I did, was start telling my children, even when they were one-year-old—that “mommy is your best friend, and she is always going to love you no matter what.” She will never be jealous of you and she will always want the best. She is always going to tell you the truth. She will always do the best thing for that. And they believe that. I understood children believe what you tell them and what you show them. And my children grew up trusting and knowing I was going to be there for them. And because they believed that, that is who I had to be. It’s funny they’ll say: “mommy when we have kids, you’ll have to come over and raise them.” And I said NO! I’ve already raised my kids—although I will be there to help.

R: What is your current view/perception of mental health? Has this changed overtime?

P: Well I think they have learned a lot of things about mental health in the last 30-40 years. You know they use to have those Asylums, where they just called people insane—and there was nothing else to do than strap them down and drug them. So that has really changed. They also found that allergies, in certain times of the seasons—they found there were people that would go off and show certain behaviors. And they would have to go get institutionalized. And they found that allergies actually caused their brain to swell and that's why they were behaving differently and acting a certain way. After that season, they were okay again. There's a lot going about mental health, they you know, "lets give em drugs" but there is a lot more research to be done. But they have found out a lot more about mental health.

R: Can you recall your first introduction to mental health or illnesses?

P: My first introduction...it was probably, I really started to look into it—I was in my sophomore or junior year in college when the story Cybil hit. Where they thought she had 13 different personalities but she really had 23. And that's when I read her book and looked at the TV. It was just amazing to me, that because of a dysfunctional parent—and we don't know why the mother was so dysfunctional—but she was abusing this little girl and torturing her. And to save herself she took on different personalities to help her survive. They just let the abuse go on. And I remember that having a profound effect on me when I had my own children, and my husband—you know when you tell your children don't let anyone touch you. And that you can always tell mommy. But sometimes they're

still afraid to tell. I told them I was always going to believe them, no matter what. If its my brother, uncle mike, or even if it's daddy. And I told them—in front of my husband—if there is something uncomfortable going on, I am going to believe them. And then I told him that if they come to him and say “mommy is hurting me,” don't poo poo it off. You have to look into that. I may not be sick now, but I could become sick. People don't start out as monsters, but when you get sick—even by tumor, they become ill. Just because I'm the mommy doesn't mean I might be always right. Don't let anyone keep hurting you.

R: Has anyone influenced your beliefs about mental health? If so, how? If not, where do you derive your current understandings?

P: I took a lot of courses also—at normal psych and different course work. I wanted to understand more about the human brain—and the more I got into it, the more I under stood. So I am very open and very sympathetic. When I see people labeled mentally ill or people say they're careful—and you have to be careful. Because whatever is happening to them, it can happen to you. And they say God teachings you lesson, and people will say God is punishing you. And I don't think it's necessarily punishment, but I don't think God is punishing you—he is teaching you and opening up another avenue. So that you can see, so that you can understand.

R: How would you react to your children claiming they had a mental health concerns? Is there a method or thought process you would employ?

P: Oh my gosh, if one of my children came and said to me “Mom, I think I have mental health problems. I think this and I think that.” We would certainly have to talk about that. And I would work with them to get them some help. I mean, absolutely, I would work with them to get them some help. No shame—well we would try to keep it confidential, but the most important thing for me is my children. If they need help...

R: Have you ever turned to any non-medical institutions, for medical concerns (i.e. Church, community centers, etc.)?

P: Umm, I think God has just been so good to me. I haven’t had major issues that doesn’t come with life. My dad died, and I wasn’t upset I just prayed God would take him to heaven. And I thanked God for giving me the years I had with him. My mom passed away, I never had uh...I didn’t turn to a minister or community factions. I really felt I had family in my life I could talk to. And God, he always answered me and gave me the support I needed.

R: Any final thoughts about anything previously discussed? Comments?

P: Um, as I say I may ramble sometimes—but pretty much everything I told you is how I feel. I think this topic is important and there is still so much we don’t know about it.

R: Alright, well thank you so much for doing this study.

Participant 10

R: Hello and thank you for doing this interview. So my first question is: What does parenting/being a parent mean to you?

P: Parenting and what does it mean to me? Well, hmm being a parent to me—I see it as, really an opportunity for me to impart onto two lives opportunities for them to flourish in our community. So they can give back and be productive members of society. And also the opportunity to just engage with them and be an example for them throughout their life. I see parenting as certainly a gift—I’ve always taken it very seriously.

R: How would you identify your relationship with your child? Why?

P: I feel that I have a very good relationship with my children—I have two children—and I feel I have a very strong relationship with them. Um, I always try to be there for them. And sometimes that can be hard as a parent, earlier in their development. You find yourself wanting to give more direction, which is good, they need that at that age. As they start to get older—meaning 12-13 years old, you want to empower them. So that if they make mistakes, you want them to learn from it. You want them to feel empowered to get it right. I would say I have a good relationship with my children, I really do. We have good communication. We are very open with each other about our feelings. If we have a disagreement, we refuse to not address it. That’s just important to me, that they can come tell me. That communication has always been very important to me. I just love spending time with my children.

R: How have you maintained this relationship status?

P: Well, I’ve maintained it because of the effort I put into it. Keeping our communication open and our relationship strong. To being there for my

children—because they know they can count on me. I think you have to balance that, because sometimes as a parent you want to rush to every trouble they have and want to fix it. I’m a fixer, I want to fix things by nature. But I am learning, that there are some things I can’t fix—that I shouldn’t fix. If I do, I am hindering their growth and their ability to work through problems. Because that’s important, I’m not always gonna be there for them. And they’re adults now, so it’s a lot better now.

R: What is your current view/perception of mental health? Has this changed overtime?

P: In relation to the black community?

R: Either or

P: I think that mental illness is certainly...it’s just bad. I believe it exists—I believe that is an illness. I know in our black community, it’s a little bit of a taboo. It’s not to be talked about. Everyone would always say “we don’t talk about that.” Just from growing up myself as a child, I can remember some of the older generational people saying. They just didn’t expect it to be something in the black community. It wasn’t the norm. It was something that was always given an excuse: that person was just weak, or they needed to pray, or they just needed more faith. But I do know it exists, it is real, it is something that crosses all racial lines. It certainly is real, I have come to realize it is real. And if you think about human nature, it’s part of who we are. Some people can handle stress and...we handle it differently. And so, maybe some individuals are not as emotionally

strong to handle certain pressures in our world today. You know today there are just so many pressures, more and more reasons and why you have to excel. These societal pressures on people—that can really take a toll on you. I remember a person I went to high school with, who went on to be very well off. He became a dentist with a great family. From what I could see he had the perfect life, everything was fine. And then, his business just hit a bump in the road and some family troubles—and then the next thing we know he was facing some mental challenges and lost his dentistry. He is doing a lot better now, sorry I went off on a little tangent.

R: Not a problem at all, that leads into my next question. Can you recall your first introduction to mental health or illnesses?

P: Hmm, you know I—part of my profession, being a teacher, and one of my degrees is in special education. And I can remember working with some family's—and the challenges of having a disabled child. There was one mother who was going through a rough time. There was just a lot of emotional instability with her. She often dealt with bouts of depression. That was my first encounter, with a parent. And she actually disclosed that to me and talked to me about it.

R: Let's talk about mental health and your family. Have you ever discussed mental health with your family? If so, how did you go about doing so? If not, is there a reason?

P: Um, I know that I certainly talked to my children—we have all sorts of conversations about various topics. So I know we've talked about that—about

friends and classmates. My husband and I will talk about that topic too. I am not reluctant to talk about it—and when I do talk about it, it is normally with my family. You know, I don't really talk to strangers about it. It's just mainly been family and the individuals who have opened up to me. I try to encourage and help them to see the goodness in themselves.

R: How would you react to your children claiming they had a mental health concerns? Is there a method or thought process you would employ?

P: How would I react? Well certainly I would want to help them. I would want to listen to what they feel—to what they feel is the pressure in their life. And knowing me, the helicopter mom that I am—I would want to seek help for them. I would want to really find out...if it is. If that is what it is. I would just have to know that, that's just me. I would have to know that, to have that medical expertise. And I would not get mad at it, I would want them to find some peace. So I would seek that medical aspect of it, I would encourage that. Because of my faith, my belief that I have—I would certainly pray for my children. That's just who I am so certainly that is something I would do. And just be there for them, if they need me. I would try my very best not to ask "are you ok" a million times. Try to help them lean on my faith, through prayer.

R: Have you ever turned to any non-medical institutions, for medical concerns (i.e. Church, community centers, etc.)?

P: I certainly turn to the Church. And its part of the community, for me, my family will always be a force for me. Family means my sisters and brothers, and of course my husband. My family and church are my primary sources for support.

R: Any final thoughts about anything previously discussed? Comments?

P: No I don't. I think your topic is one that is certainly very prevalent. I think it is important. I think mental illness is more widespread in the black community than we realize or would like to accept. I am proud to be apart of this study and share my thoughts on the subject. I hope I've been helpful.

R: Alright, well thank you so much for doing this study.

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