Taylor & Francis
health**sciences**

BARRIERS TO MENTAL HEALTH CARE ACCESS IN AN AFRICAN AMERICAN POPULATION

Vicki Hines-Martin, PhD, RN, CS
University of Louisville, School of Nursing, Louisville, Kentucky, USA

Mary Malone, MSN, MA, RN
Nursing Program, Jefferson Community College, Louisville, Kentucky, USA

Sanggil Kim, MSN, RN
Doctoral Candidate, University of Kentucky, Lexington, Kentucky, USA

Ada Brown-Piper, MSN, ARNP, CS
Central State Hospital, Louisville, Kentucky, USA

Emphasis has been placed on understanding the mental health disparities that exist within minority populations in the United States. Disparities are of particular importance when examining access to services. This paper reports findings from a NINR-funded qualitative study that examined the barriers to mental health care service use in an African American low-income population. Barriers were identified at three levels—Individual, Environmental, and Institutional. Fourteen barrier categories were identified within those levels with three categories common to the majority of participants. The identified categories provide insight into the process of seeking services within this population and provide direction for future investigation.

Disparities in access to mental health services persist across racial and ethnic groups in the United States. According to the U.S. Department

of Health and Human Services (DHHS, 2001), racial and ethnic minorities have less access to mental health services than do non-Hispanic whites. In spite of the consensus that disparities exist between ethnic/racial groups, the mental health system has much to discover and address in its attempt to meet the needs of those populations. Considering that the incidence of mental illness is similar across racial and ethnic groups, those minority individuals who require mental health services care carry a greater burden from unmet mental health needs. Although the available data on disparities is woefully incomplete for all minority groups, the literature regarding mental health disparities in African American populations has been generated in more detail than other minority groups. Literature on differences in mental health care access and use in the African American population has increased significantly since the late 1980s. The available literature has illuminated the existence of those differences but has not explicated the mechanisms underlying them. Therefore, exploration of mechanisms underlying decisions, facilitators, and barriers related to service use in this population holds great potential for better understanding within and across cultures. Identifying and understanding each of these aspects related to mental health service use ultimately enhances culturally compatible service delivery (Wang, Berglund, & Kessler, 2001).

BACKGROUND AND SIGNIFICANCE (LITERATURE REVIEW)

The Surgeon General's report on culture, race, and ethnicity (DHHS, 2001) reinforces the need to consider culture, race, and ethnic background, and identifies access to care as a major issue involved in mental health services disparities in African American populations. The report identifies numerous barriers to mental health services for African Americans. These barriers include lack of or inadequate insurance coverage (Snowden & Thomas, 2000), disjointed services (Smedley, Stith, & Nelson, 2002), location of culturally specific services (Swartz, Wagner, Swanson, Burns, George, & Padgett, 1998), society's stigma toward mental health disorders (DHHS, 2001), and cultural insensitivity of mental health personnel (Swartz et al., 1998). Health care providers' lack of cultural competence results in inadequate detection and recognition of mental health symptoms in African Americans, thus leading to improper diagnosis (Borowsky, Rubenstein, Meredith, Camp, Jackson-Triche, & Wells, 2000). Studies reveal that African Americans encounter a multitude of additional internal and external obstacles that impede access to mental health services. These include fear of institutionalization (Swartz

et al., 1998), gatekeeper's biases (Snowden & Cheung, 1990), individual perception regarding the magnitude and source of mental problems (Millet, Sullivan, Schwebel, & Myers, 1996), and concern regarding care for family members at home (Scheffler & Miller, 1991).

Because access to mental health services is affected by both internal and external factors, examination of the phenomenon must be grounded in an ecological framework of health service use. One such framework is Andersen and Newman's (1973) Societal and Individual Determinants of Health Service Utilization. This framework for viewing health service use takes into account both environmental and individual determinants. The model was developed not only to facilitate understanding of how individuals use services but also to define and measure factors associated with varying degrees of access to health care. Further, the model aims toward understanding the extent to which a given component can be altered to influence change. This process is identified as component mutability. Andersen and Newman (1973) identify three primary aspects within this model—Societal Determinants (technology and norms), Health Services Systems (resources and organizations), and Individual Determinants. Key components within the Individual Determinants aspect were predisposing factors (demographic, social structures, beliefs), enabling factors (family, community), and illness level (perceived, evaluated).

Andersen and Newman's (1973) model is appropriate to examination of factors related to African American mental health service use. As identified in the previously mentioned literature, societal factors greatly affect the mental health of African Americans. Health systems have demonstrated lack of congruence with the mental health needs of African Americans. Finally, many of the Individual Determinant components of the model have been identified as influential in research about African American family processes and social functioning (Chatters, Taylor, & Neighbors, 1989; Hines-Martin, 1992, 1998, 2002; McAdoo, 1997). Although Andersen's model (1995) has evolved to address population-based needs and other health care system issues, the impact of individual factors remains a central theme. Employing the Individual Determinants aspect of the model provides a perspective for interpretation of data and provides an opportunity to evaluate the appropriateness of the model in relation to the experience of this underserved population.

PURPOSE OF THE STUDY

Current literature identifies that understanding the effects of culture and society on mental health, mental illness, and mental health services

is essential to developing mental health services that are more responsive to the cultural and social contexts of racial and ethnic minorities (DHHS, 2001; Josiah Macy Foundation, 2002; Office of Behavioral and Social Sciences Research [OBSSR], 2001). The Office of Behavioral and Social Sciences Research—Executive Summary (OBSSR, 2001) cites the following recommendations for research.

> Expand research on health care services and health care seeking to address social, cultural, economic, and policy factors that influence access to care . . . Study the ways in which individuals draw on cultural models relating to health and illness to guide decision-making (p. 3, 12).

Although there has been increasing focus on the disparities that exist between African Americans and other populations, several key issues are as yet unexplored. These issues are (1) the processes through which access differences exist within this multicultural society, (2) the influences on decisions to use mental health services, and (3) the potential directions for change in mental health care systems as this knowledge is increasingly revealed.

African American populations have faced recurring problems in obtaining appropriate care and few studies have examined this phenomenon from the above-mentioned perspectives. Therefore, a qualitative study was undertaken to explore the experience of help-seeking for a sample of African American males and females who sought public mental health services for the first time. This paper reports findings regarding the barriers to mental health services, how those barriers affected the help-seeking process, and the importance of those barriers for the study participants.

METHODS

Design

The reported study was one component of a mixed method 3-year NINR-funded study examining mental health service use in African American adults. A grounded theory, qualitative approach (Glaser, 1978, 1992) using reiterative comparisons, theoretical sampling, and saturation of codes, categories, and constructs was used to describe the help-seeking process identified as the cognitive and behavioral pathways toward first time mental health service use. This report describes findings from the qualitative inquiry of the perceived barriers to mental health service use.

Sample

The participants in the study were African American, low-income adults who sought mental health treatment in one of six selected public inpatient or outpatient settings within the previous 12 months. Additional inclusion criteria for the study included:

- Age 18 or older
- First-time, voluntary access to mental health services as an adult for any mental health disorder (excluding dementia-related disorders and a primary diagnosis of substance abuse)
- Consent to be interviewed and share experiences with interviewers
- Able to express themselves clearly in English
- May have had prior treatment for a mental disorder in a primary care setting
- May have had prior substance abuse treatment
- Considered clinically stable and able to participate by their mental health care provider

Setting

The setting for the study was a southern border state with a population of 4,041,769 citizens, that is estimated to have an African American population of 295,994. Of that population, 130,928 African Americans resided in the county in which the study was conducted (Kentucky State Data Center, 2001). The prevalence of significant mental illness in the state was estimated to be 25,821 adults (Regional Planning Council #6, 2000). The county that functioned as the setting for the study provided public, mental health care services through one 158-bed, state-supported inpatient setting; one university-affiliated, tertiary-care hospital that housed two inpatient psychiatric units, an emergency psychiatric service, and outpatient mental health services; and a multisite, outpatient community mental health care organization. Sites selected from these mental health service organizations were used for participant recruitment.

Instruments

The Qualitative Interview Guide was an 11-question, semistructured tool used to identify processes and factors that were part of the help-seeking process and mental health service access. The development of the guide was based on qualitative inquiry principles (Glaser & Strauss, 1967; Morse & Field, 1995; Sanjek, 1990) and two pilot studies completed by the principal investigator. Questions focused on the process of

problem identification, steps taken to address the problem(s), resources used, desired resources, barriers and facilitators to problem resolution, duration of the help-seeking process, and perceived benefits of formal mental health services which had not been achieved through prior problem solving strategies.

The Field Note Recording Guide provided a format for documenting contextual and nonverbal data, reflections, and salient points related to qualitative interviewing. Field notes also aided in the tracking of related observations across interviews as the study progressed (Morse & Field, 1995).

Procedure

Prior to beginning the study, Institutional Review Board approval was obtained from the university and each agency participating in the study. The study team was composed of the principal investigator who is a doctorally prepared advanced practice mental health nurse, two master's prepared advanced practice mental health nurses, and one master's prepared nurse who is a doctoral candidate in nursing. All team members except the doctoral candidate were African American. To minimize potential interview barriers, only African American team members were used as participant interviewers. All study team members were trained in study techniques and protocols prior to initiation of the study. Participant interviews were observed by the principal investigator at intervals throughout the study to maintain consistency and adherence to study protocol.

To recruit participants investigators met with mental health care providers from the community/outpatient and inpatient settings to explain the study and inclusion criteria. Written materials developed for the study were provided to all care providers to facilitate recruitment. A protocol was established and maintained by the study team that included weekly contact with each site to communicate with providers and to facilitate subject recruitment.

Using information developed for the study, all eligible clients were initially informed of the study by their service provider. Potential participants who met the inclusion criteria (as determined by the care provider), expressed interest, and gave permission to meet with team members were contacted by phone or in person by one of the interviewers. An interview site was selected by the participant based on the convenience of the volunteer. At the beginning of the interview, participants were screened to verify continued interest, confirm eligibility,

and provide details about the study. Written informed consent was obtained. Participants in the qualitative aspect of the study were interviewed using a semistructured interview guide developed for the study. Interviews were audio taped for accuracy and field notes were taken at the time of the interview. Interviews ranged from 23 minutes to 60 minutes in length. Participants were paid an honorarium at the end of the completed interview. Participant data were coded by number only. Audiotapes were transcribed by a professional transcriptionist with identifiers removed. Throughout the study, all data were placed in a locked file separate from participant identification information.

Data Analysis

After audiotapes were transcribed verbatim, they were reviewed for accuracy by the study team. Interview data were organized using NUD*IST software (1997). Field notes were synchronized and used as part of the data under analysis. Data were initially clustered according to interview guide questions. Throughout the study, reiterative data analysis were subsequently performed to reveal common responses (content and semantics), categories, themes, and patterns. Data were collected and analyzed to the point of saturation. The theme of *barriers to care* was further examined to identify categories and patterns in participant responses. Verbatim quotes from study participants were selected to illustrate the identified themes and categories. All data were audited at regular intervals by the two advanced practice mental health nurses and the master's prepared, doctoral candidate to ensure scientific adequacy and rigor (Lincoln & Guba, 1985; Morse & Field, 1995; Sanjek, 1990).

FINDINGS

Sample

A total of 24 participants were involved in the qualitative study. The mean age of the participants was 34.63 years (range = 20–59; $SD = 9.60$ years). More participants were female ($n = 13$, 54.2%; males $n = 11, 45.8\%$). The length of time, from the point when the participants identified a problem to the time they sought treatment as an adult, ranged from 1 day to 14 years (median 5 years). Other descriptive characteristics are identified in Table 1.

TABLE 1. Demographic Characteristics of the Sample
(*N* = 24)

Characteristics	*n*	%
Marital status		
Single	13	54.2
Married	3	12.5
Divorced/separated	8	33.4
Education		
Some high school	8	33.3
High school graduate or GED	5	20.8
Beyond high school	10	41.7
Employment and insurance coverage		
Unemployed with MH insurance coverage	7	29.2
Unemployed without MH insurance coverage	13	54.2
Employed with MH insurance coverage	1	4.2
Employed without MH insurance coverage	3	12.5
Primary diagnosis		
Major depression	10	41.5
Adjustment	4	16.7
Bipolar	3	12.5
Psychosis	3	12.5
Other	4	16.7

Barriers to Mental Health Service Use

Barriers to mental health service use identified by the participants occurred at three levels—Individual, Environmental, and Institutional. Individual barriers reflected factors that inhibited seeking help that originated from within the individuals themselves. Environmental barriers reflected factors that occurred within the milieu of (external to) the affected individuals which inhibited attempts toward or increased difficulty of efforts to seek help. Institutional barriers were factors related to accessing the resources identified by the participants. Table 2 presents each barrier level and categories that reflected the experiences of these participants.

Although a variety of experiences were identified by these participants, the barrier categories most frequently reported were related to Thoughts/Knowledge Deficit, Beliefs/Attitudes/Values, and Family/Significant Others/Community. The categories of Thought/Knowledge Deficit and Beliefs/Attitudes/Values were identified within the Individual barrier level. The Family/Significant Others/Community category was identified within the Environmental barrier level. A majority of the participants identified Thoughts/Knowledge Deficit as a

TABLE 2. Barrier Level and Categories

Level	Category	Definition
Individual barriers	Fear/mistrust	Of the responses of others resulting from revealing the problem; mistrust of others' concern
	Denial/avoidance/ repression/choice not to reveal	Based on actions or statements of the individuals during interview indicating failure to recognize or express negative, illness-related experiences
	Beliefs/attitudes/ values	About self, situation, or future outcomes as they relate to motivation vs. help-seeking; principles held that guide day-to-day living
	Thoughts/knowledge deficit	Obstacles related to understanding the problem or situation; limitations in awareness of possible solutions, strategies, remedies, and resources
	Disability	Physical or cognitive limitations in addition to mental health concerns that adversely affect the help seeking process
	Economic	Financial obstacles or obligations that adversely affect the ability/willingness to obtain help
	Impact of illness/ trauma	Level of impairment significant enough to limit rational thought affecting help-seeking behaviors/problem solutions
	Responsibilities	Competing obligations that block behavioral change and/or minimize the priority of help seeking from the individuals' perspective
	Nonadherence	Once initial problem identified, noncompliance with, interruption of, and/or discontinuation of recommended treatment modalities
Environmental barriers	Family/significant others/community	Identified individuals or groups that adversely affected help seeking through influence on the participant
	Resources	Difficulty in finding options for mental health and supportive services within the environment that are identifiable and available as perceived by the participant
Institutional barriers	Time/limitations/ capacity	Resource barriers related to length of time waiting for acceptance, limitations for acceptance, and capacity vs. community need
	Gatekeepers	Negative impact of professionals' attitudes on access to services as perceived by the participant
	Rules	Guidelines for identified services that inhibited service access and/or use

significant factor in where, how, and when they sought solutions to mental health problems.

The category of Thoughts/Knowledge Deficit was defined as obstacles related to understanding the problem or situation and limitations in awareness of possible solutions, strategies, remedies, and resources. Participants discussed their unawareness that the problems they were experiencing were "mental health" problems. Most participants identified mental health and illness as dichotomous states. Many verbalized that they did not think that they were "crazy" and therefore did not need mental health services. Participants thought that the problems they were experiencing were normal responses to difficult life situations and they just needed to keep trying to manage their difficulties. As problems mounted or reoccurred and interfered with their ability to function, they felt ill equipped to identify strategies to address those problems. Acquisition of sufficient information leading to access of mental health services occurred over varying lengths of time and was generally acquired through the extensive efforts of each participant or their family. Participants expressed in many ways the process of "making sense of" or giving meaning to their experiences and problems from the "information bits" that they gathered over time. The process of making sense of these problems for many required years. One participant, who had experienced child sexual abuse, provided the following perspective.

> I should have been, actually been in one of these [programs]...a long time ago. Probably should have come to one of these a long time ago, but I thought nothing could help me. I thought nobody would ever understand. I thought I was the only one like this, cause the things that I did and the things that was happening to me when I was little, just, I don't, I don't understand how anybody could be doing that type of stuff. I mean, that [they] could even think that low, you know.

The category of Beliefs/Attitudes/Values also was revealed as an important one for many of the study participants. This category was defined as one involving perceptions about self, situation, or future outcomes as they relate to motivation versus help seeking and principles held that guided day-to-day living. Critical to the understanding of these participants and this barrier category were the socioeconomic and political limitations experienced by this population. Most experienced economic pressures, limited control over important aspects of their lives, and uncertain futures. What they *did* have control of was the persona they presented to others and the perception they held of themselves. Most of the participants in this study held views of themselves that assumed

some degree of self-efficacy in relation to managing their day-to-day living, no matter how difficult. They identified roles in daily life that were critical to their self-image, and maintenance of these roles functioned as a barrier to problem identification and help seeking. Many felt the need to avoid asking for help because they needed to be "strong" regardless of the growing inability to handle deteriorating circumstances. Still others felt that they experienced lives that were much better than others in their environment and felt as if they were not entitled to acknowledge that they were experiencing problems for which they needed assistance. Not until the problem became untenable, and affected individual and family functioning, was help sought out. Two participants expressed those sentiments this way.

> I think it would, not so much as other people I would think my kids would think less of me and, you know, people would look different at me. You know, I wasn't the smartest person, but I sure wasn't the dumbest. Right now I'm closer to dumbest instead of smart. So I'm just taking it one day at a time.

> I just needed somebody in my family to ask me "*was I okay*?" . . . [my family] just always have had high expectations of me so they know I'm a go-getter. They like "she's doing fine. She got that house. She's paying her bills, nothing been cut off." You know. "She looks good. The kids is looking great." So, I just needed that, "*are you okay*?"

The third significant barrier category that was revealed by study participants was Family/Significant Others/Community. Family/Significant Others/Community identified individuals or groups that adversely affected help-seeking through influence on the participant. This very important aspect was discussed by many of participants. Some participants expressed the desire to follow religious advice, seek pastoral counseling, and avoid mental health services. Others expressed fear of being labeled by others as mentally ill with its associated stigma, as well as a hesitancy in revealing private emotions and thoughts.

> I got brothers and they like, they might not mean no harm, but they would use that as a joke and I don't think I would like that too much and I would probably lose my temper. And I wouldn't like that cause that's something that you would think is a very private thing . . . Right now in mind is like I don't really want too many people to know. Cause in a way I'm ashamed and in a way I'm hurting. There's just a whole [lot] of different mixed feelings with that. What I'm going through now and I'm trying to feel good and trying to smile about things every day and trying to keep looking up on the bright side of things. They're gonna get better.

Most striking in this category is the limited number of incidences in which family members, significant others, and influential community members identified mental health services as a possible resource early in the help-seeking process. However, when family members or friends identified mental health services as a resource, over the course of time those services were sought out. This was particularly true when those individuals making the suggestion had personal experience with mental health care and had positive outcomes.

Although the above-mentioned categories represent the most commonly identified barriers to care, others were identified in this study. Table 3 presents each of those categories and exemplars from participant's experiences.

Throughout the study, participants readily shared their experiences. Those experiences reflected aspects that were identified within the Andersen and Newman (1973) model. The key barriers to mental health service use as identified by the study participants are illustrated in Figure 1. The diagram depicts study findings using concepts modified from the Andersen and Newman (1973) Individual Determinants framework.
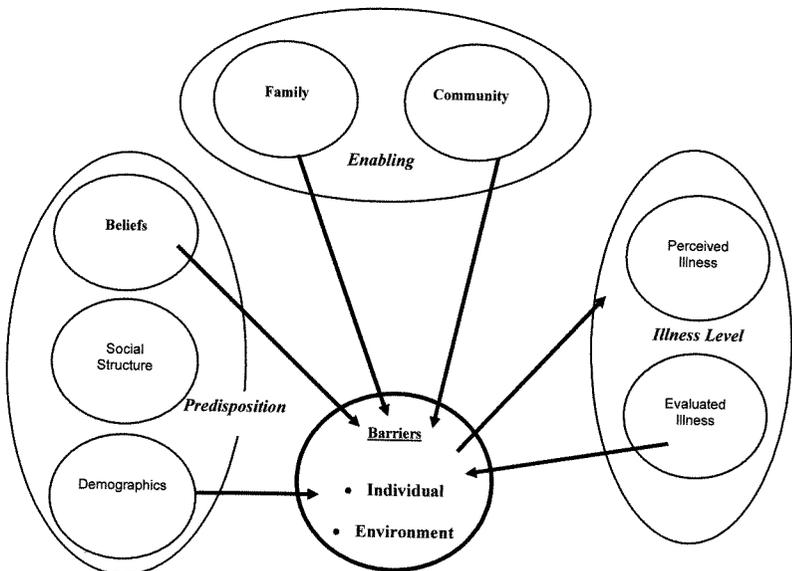
FIGURE 1. Key barriers to mental health service use as identified by study participants. Concepts are modified from the Andersen and Newman (1973) Individual Determinants framework.

TABLE 3. Perceived Barriers to Mental Health Service Use

	Exemplar
Individual barriers	
Fear/mistrust: Of the responses of others resulting from revealing the problem; mistrust of others' concern	"I didn't talk about it because I was as a kid growing up I mean if there was any little thing wrong with you, you know it was a point for not just neighborhood kids to attack you but your own family, brothers and sisters to attack you. So I felt like, you know, it wasn't worth going through all that to tell anybody, to tell the therapist or my mom or anybody else what was causing me to act the way I was and that just continued on, right now today well this episode here is the first time I've ever told anyone, but yes there is a voice inside my head and yes he does talk to me, he does tell me to do things I shouldn't do."
Denial/avoidance/ repression/choice not to reveal: Based on actions or statements of the individual during interview indicating failure to recognize or express negative, illness-related experiences	"Yes, it was kind of scary, definitely, definitely, definitely scary. You know and that day is coming back. It's not coming back as quickly as I would like it to, but day by day it's coming back. It's something that besides sharing it with you I don't want nobody to know actually, not in my family."
Disability: Physical or cognitive limitations in addition to mental health concerns that adversely affect the help-seeking process	"By me not working, being able to do anything, I have never asked nobody for anything. I shouldn't expect it, something to kick off for help to be right away, but I did. There was the disability people, you know, I thought when they told me 120 days, you know, they'd be able to do something. Look, you know, I wrote them a serious note telling and explaining to them and they said we'll get someone to help us understand about you. My sister look it up on a computer and like type it out. I did, I put a lot of effort into it explaining my situation and about myself and for them to tell me that I was rejected, to try again."
Economic: Financial obstacles or obligations that adversely affect the ability/willingness to obtain help	"Just giving up on life, not being able to have a job, seeing no brightness in my future and just wanting my life to end . . . No job, no things that are hard, no partner . . stuff like that."

(Continued on next page)

TABLE 3. Perceived Barriers to Mental Health Service Use *(Continued)*

	Exemplar
Impact of illness/trauma: Level of impairment significant enough to limit rational thought affecting help-seeking behaviors/problem solution	"It was the other voice. Whenever something doesn't go quite, the way I want it to, the other voice will come up and tell me things like 'I told you so,' 'You're no good,' 'Go ahead, kill yourself, nobody's gonna care,' 'they're better off without you.' And, he does this a lot, you know to screw me up and this one particular time, you know. I actually started hearing it and believing him and I was just ready, just to, I was ready to go."
Responsibilities: Competing obligations that block behavioral change and/or minimize the priority of help seeking from the individual's perspective	"I was trying to do too many things. I was trying to go to school so I wouldn't be sitting at home. I was trying to look for a job after school. And before school I was trying to make sure my kids had everything they needed and they were okay. And that prevented me from getting any help. Cause I thought I was supposed to be there and I just. . . . Mom's supposed to do this. This is my job. This is what I do. Prepare my kids and let them know they're going to be okay. Try to affirm to my kids that we are okay. Assuring them."
Nonadherence: Once initial problem identified, noncompliance with, interruption of, and/or discontinuation of recommended treatment modalities	"I thought I was doing pretty good, evidently not. After [the first hospital], I again went to [the second hospital]. I went back to [the second hospital]. But, that was a morning program and the counselors there, I don't know. To me they were trying to get something out of me, that, an attitude I just didn't have. They would try to frustrate me to make me angry. I guess to, I don't know, I guess to come to some kind of conclusion about how I was. I just didn't, I just [couldn't] bear with that. I told her that I didn't want my job to know and they would force that issue. So I just, I just left their program."
Resources: Difficulty in finding options for mental health and supportive services within the environment that are identifiable and available as perceived by the participant	Q: How much time elapsed between the time you got out of jail and the time you got to the program? R: It took me four months to get in. Q: Okay. It took you four months. So you tried when you first got out? R: No, I stayed incarcerated until I. . . Q: You stayed in jail until you got here [program], okay? So did you have to stay in jail until you got here? R: Um hum.

TABLE 3. Perceived Barriers to Mental Health Service Use *(Continued)*

	Exemplar
Institutional barriers	
Time/limitations/capacity: Resource barriers related to length of time waiting for acceptance, limitation for acceptance, and capacity vs. community need	"'You're gonna have to wait such and such amount of time and you are going to have to come in, and you're gonna have to stay.' I'm like, I want to come in right now tonight, right at this minute, I would like to get in the car and drive there and just that's it. Well Mr. [name] you'll have to go through this, anybody can. No man, I'm not going through shit, I'd go fix me another drink."
Gatekeepers: Negative impact of professionals' attitudes on access to services as perceived by the participant	"They, I heard them talking, 'I guess some of them people just don't need any help.' I guess some people are playing games, but I heard her say it like [I] can only stay here 72 hours . . . and I said, 'you know, [you] can help everybody else why can't they help me? You know I got problems too.' She said, 'well, you can't take care of yourself out there.' And then I don't know what to say and really I was really wasn't talking to her and then she looked at me and picked me out as if I'm just trying to get something off the system or something."
Rules: Guidelines for identified services that inhibited service access and/or use	"And I couldn't get no help. Every time I turn around and try to get some help everybody turned me down on account of I've still got an open court case."

CONCLUSION AND IMPLICATIONS

Participants of this study demonstrated perseverance, courage, and strength as they experienced mental health problems and pursued solutions. The setting for the study included multiple sites for mental health service access for lower income individuals. And although services could be found for those individuals with serious mental health problems, these service providers were experiencing decreasing financial resources, and limitations on the numbers of low-income clients that could be served. Individuals at this socioeconomic level had a formidable financial barrier to mental health services.

However, the economic aspect was not of foremost concern for these study participants. The perceived barriers identified within this study focused on individual, environmental, and institutional levels. Individual barriers were most prominent with barriers in the areas of knowledge

and beliefs being expressed most frequently by participants. Identified barriers external to the individual frequently focused on family and community. The most commonly expressed barriers were especially important when examined in light of the fact that most participants had experienced illness or problems over a long period of time before barriers were identified and overcome. Many participants experienced problems beginning in childhood and adolescence. Opportunities for early intervention were hindered, and severity of problems increased. Even in the face of these obstacles, participants in this study identified needed services with little knowledge or guidance.

The journey toward access to mental health services for these participants reflect many of the findings found in previous research. They experienced lack of insurance coverage, stigma, gatekeeper biases, and difficulties understanding the magnitude and source of their problems. Findings from this study also provided insights that were not reflected in previous research.

Participants in this study revealed underlying reasons for behaviors that contributed to individual barriers. Most participants clearly presented a view of mental illness as "all or nothing." In addition they illustrated how difficult the process was of making sense or giving meaning to their experiences early in the trajectory of the mental health problem. In regard to beliefs held by study participants, having some sense of control over their seemingly tenuous lives is an important deterrent to seeking services. Efforts to be "strong" and minimize the experienced problems delayed help-seeking. Also of importance is the environmental void that exists for these participants in relation to information, support, and encouragement toward mental health service use as a strengthening opportunity early in problem development. These factors appear integrally related and indicate barriers that comprise the maze toward mental health care.

Findings from this study suggest directions for future research in the following areas. Stigma is an important concept that needs further exploration in relation to deconstructing this concept into its components and identifying those components that are mutable to change. In addition, there is the need to examine how we label behaviors as rooted in stigma when investigation may reveal alternative motivations for the observed behaviors. Understanding this important concept in relation to mental health utilization appears critical to addressing disparities.

The reported study clearly illustrates that understanding how individuals think through and discuss their struggles to problem solve is key in facilitating equitable mental health service use. Building a body of knowledge regarding how we as professionals facilitate this process

through patterns of communication requires expansion of our research methods to include ethnomethodologically derived approaches such as conversation analysis. Participants expressed a lengthy process involved in gathering sufficient knowledge to act successfully. Study of preventive approaches for at-risk populations using cross sectional and longitudinal designs to identify mental health benefits holds potential for decreasing mental health disparities. However, in an environment that increasingly limits mental health services due to shrinking resources, cost-benefit studies of preventive approaches also must be a priority.

Individuals within the study experienced multiple stressors in addition to, and as a result of, their mental health problems. An important area of inquiry with this population is "What is the effect of cumulative stress on the emergence and progression of mental health problems experienced by these individuals?" Questions focused in this area would further an understanding of the process of "kindling." Although kindling theory was initially applied to neurobiological structures and psychopharmacological functioning (Gualtieri, 1991; Post & Weiss, 1992), kindling theory has evolved into an important explanation of the interaction of experience and neurobiological imprinting in the development of some mental disorders. The theory states that a genetic predisposition coupled with ongoing stress or stress during crucial phases of development may result in a neurobiological vulnerability that may lower an individual's threshold for developing some psychiatric disorders (Friedman, 1994; Ghaemi, Boiman, & Goodwin, 1999; Jetty, Charney, & Goddard, 2001; Post, 1992). Postulating that kindling theory may be applicable within any population that experiences multiple stressors such as those in this study is an important area for inquiry.

If multiple sources of stress potentially increase vulnerability to the development of psychiatric conditions, interventions that systematically address stress with a focus on early intervention should be examined for efficacy. With an ecological perspective, stress reduction interventions must consider not only the individual experiencing the problem but also those other individuals who support, assist, and are affected within the family and community context. Intervention modalities that address stress with an ecological approach, based on the Progressively Lower Stress Threshold Theory (PLST; Hall & Buckwalter, 1987), could be tested with African American clients. PLST states that there is a progression of affective, behavioral, and cognitive changes that occur with the progression of a mental health condition. This theory has been used with victims of dementia, specifically Alzheimer's disease. Changes that occur are categorized into progressively more severe levels of response related to the disease (Gerdner, Hall, & Buckwalter, 1996; Hall, 1994).

Key groups of stressors identified within this theory such as multiple and competing stimuli, and demands to achieve beyond ability, are applicable to the sample within this study. Comparative analysis of PLST and the levels and types of responses exhibited with the study population is an intriguing direction for research. Exploring the utility of this theory for broader mental health populations is an appropriate direction for investigators. Therefore, examination of the PLST with this population seems warranted in light of the emergence of the kindling theory as an important component in the understanding of mental illness development.

When evaluating clinical practice, uncovering answers to the following questions has potential for decreasing barriers, eliminating disparities, and addressing cultural competence issues:

- How do we interface with our community and is that adequate?
- Do we help the client make "meaning" of their experience or do we provide discrete "bits" of information?
- How do we seek information from clients and does that approach eliminate or support barriers to care?
- How do we interpret client "no show" and "drop out rates" for mental health services in light of the barriers identified through research? Evidence-based practice requires that we place value in understanding individuals who cannot persevere and participate in services. How do clinical services evaluate these negative outcomes, and who really counts in the development of equitable mental health services?

REFERENCES

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(March), 1–10.

Andersen, R., & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the United States. *Milbank Memorial Fund Quarterly, 51*(1), 95–124.

Borowsky, S., Rubenstein, L., Meredith, L., Camp, P., Jackson-Triche, M., & Wells, K. (2000). Who is at risk of nondetection of mental health problems in primary care. *Journal of Internal Medicine, 15*, 381–388.

Chatters, L., Taylor, R., & Neighbors, H. (1989). Size of informal helper network mobilized during a serious personal problem among black Americans. *Journal of Marriage and the Family, 51*, 667–676.

Friedman, M. J. (1994). Neurological sensitization models of post-traumatic stress disorder: Their possible relevance to multiple chemical sensitivity syndrome. *Toxicology and Industrial Health, 10*(4–5), 449–468.

Gerdner, L. A., Hall, G. R., & Buckwalter, K. C. (1996). Caregiver training for people with Alzheimer's based on a stress threshold model. *Image: Journal of Nursing Scholarship, 28*(3), 241–246.

Ghaemi, S. N., Boiman, E. E., & Goodwin, F. K. (1999). Kindling and second messengers: An approach to neurobiology of recurrence in bipolar disorder. *Biological Psychiatry, 45*(2), 137–144.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: The Sociology Press.

Glaser, B. G. (1992). *Emergence versus forcing: Basics of grounded theory analysis*. Mill Valley, CA: The Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, NY: Aldine.

Gualtieri, C. T. (1991). The functional neuroanatomy of psychiatric treatments. *Psychiatric Clinics of North America, 4*(1), 113–124.

Hall, G. R. (1994). Caring for people with Alzheimer's disease using the conceptual model of progressively lowered stress threshold in the clinical setting. *Nursing Clinics of North America, 29*(1), 129–141.

Hall, G. R., & Buckwalter, K. C. (1987). Progressively lowered stress threshold: A conceptual model for care of adults with Alzheimer's disease. *Archives of Psychiatric Nursing, 1*, 399–406.

Hines-Martin, V. P. (1992). A research review: Family caregivers of chronically ill African American elderly. *Journal of Gerontological Nursing, 18*(2), 25–29.

Hines-Martin, V. (1998). Environmental context of caregiving for severely mentally ill adults: An African American experience. *Issues in Mental Health Nursing, 19*, 433–451.

Hines-Martin, V. (2002). Family adaptation and coping in mental health caregiving. Manuscript submitted for publication.

Jetty, P. V., Charney, D. S., & Goddard, A. N. (2001). Neurobiology of generalized anxiety disorder. *Psychiatric Clinics of North America, 24*(1), 75–97.

Josiah Macy Foundation. (2002, March). *Chairman's summary of the conference—modern psychiatry: Challenges in educating health professionals to meet new needs*. New York: Josiah Macy, Jr. Foundation.

Kentucky State Data Center. (2001). *Kentucky population research: 2000 population estimate for Kentucky metropolitan statistical areas*. University of Louisville Department for Urban Studies. [On-line]. Available: http://cbpa.louisville.edu/ksdc/kpr/popest/msa00.txt

Lincoln, Y. S., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

McAdoo, H. P. (1997). *Black families* (3rd ed.). Thousand Oaks, CA: Sage.

Millet, P., Sullivan, B., Schwebel, A., & Myers, L. (1996). Black Americans' and White Americans' view of the etiology and treatment of mental health problems. *Community Mental Health Journal, 32*(3), 235–242.

Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA: Sage.

Office of Behavioral and Social Sciences Research. (2001). *Toward higher levels of analysis: Progress and promise in research on social and cultural dimensions of health*. Bethesda, MD: National Institutes of Health. NIH Publication No. 215020.

Post, R. M. (1992). Transduction of psychosocial stress into neurobiology of recurrent affective disorder. *American Journal of Psychiatry, 149*, 999–1010.

Post, R. M., & Weiss, S. R. (1992). Ziskind-Somerfeld Research Award 1992. Endogenous biochemical abnormalities in affective illness: Therapeutic versus pathogenic. *Biological Psychiatry, 32*(6), 469–484.

Regional Planning Council #6. (2000, December). *HB 843 report: Regional plan and recommendations*. Louisville, KY: Seven Counties Services, Inc.

Sanjek, R. (Ed.). (1990). *Fieldnotes: The making of anthropology*. Ithaca, NY: Cornell University.

Scheffler, R., & Miller, A. (1991). Differences in mental health service utilization among ethnic subpopulations. *International Journal of Law and Psychiatry, 14*, 363–376.

Smedley, B., Stith, A., & Nelson, A. (Eds.). (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care* (Institute of Medicine Publication). Washington, DC: National Academy Press.

Snowden, L., & Cheung, F. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist, 45*(3), 347–355.

Snowden, L., & Thomas, K. (2000). Medicaid and African American outpatient mental health treatment. *Mental Health Services Research, 2*(2), 115–120.

Swartz, M., Wagner, R., Swanson, J., Burns, B., George, L., & Padgett, D. (1998). Administrative update: Utilization of services. *Community Mental Health Journal, 34*(2), 133–144.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—a supplement to mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Wang, P., Berglund, P., & Kessler, R. (2001). Recent care of common mental disorders in the United States. *Journal of General Internal Medicine, 15*(5), 284–292.