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Characteristics of Effective Communication About Mental Health in an African American Urban
Community: A Qualitative Analysis

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science
in Multimedia Journalism at Virginia Commonwealth University

by

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Abstract

CHARACTERISTICS OF EFFECTIVE COMMUNICATION ABOUT MENTAL HEALTH IN AN AFRICAN AMERICAN URBAN COMMUNITY: A QUALITATIVE ANALYSIS

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Bachelor of Arts, Swarthmore College, 1989

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Research has shown African Americans experience mental health issues at the same rate as the general population but seek treatment at only one-third that rate. Eleven African American low-income urban community leaders with basic training in mental health issues were interviewed about their perceptions of African American patterns of communication on mental health issues. Findings included a general consensus that the topic is generally not discussed, although passing references to a party's perceived mental illness may be made using humor. When such discussion does take place, it happens only in a "safe space" with a trusted dialogue partner. Non-verbal cues are an important element of these conversations, as are non-judgmental, attentive and purposeful listening. The participants report that community members who did not receive the basic mental health training speak with great disparagement of those they perceive to be mentally ill.

Introduction

Thomas R. Insel (2008), director of the National Institute of Mental Health, estimated in 2008 that mental illness costs the American economy \$317 billion per year. This amount did not include the costs of incarceration, homelessness and premature death, but it still added up to more than \$1,000 per year for every person in the United States. Given the trajectory of American health care costs, that amount has almost certainly increased in the years since.

Glanz, Rimer and Viswanath (2008), in their much-cited text *Health Behavior and Health Education: Theory, Research and Practice*, point out that the course of human health is heavily determined by the social influence of interpersonal communication. How people communicate about health (or don't—witness the early days of HIV/AIDS) is a strong determinant of the health of a population. For people to understand what causes a health condition, their susceptibility to it, its severity and ways to prevent or mitigate it, people must learn. For a population to improve its health, the learned information must be shared. There is no learning without communication. Kirmayer (2012) says any effective healing system must have discourse.

It therefore follows that for the nation to lessen the many costs of mental illness, we need to know how we communicate about mental illness and about its inverse. The worse the health of the population, it may be inferred, the more badly this knowledge is needed.

In 1999, the United States Department of Health and Human Services issued a landmark look at mental health in America with *Mental Health: A Report of the Surgeon General*, almost 500 pages on the state of the research and treatment of mental health issues at the close of the twentieth century. However, research for that document and others (e.g., Healthy People 2010)

revealed the existence of separate and unequal classes of care in the field of American mental health (Snowden, 2012).

In 2001, Surgeon General David Satcher issued a supplement to the 1999 report, entitled *Mental Health: Culture, Race, and Ethnicity*, described as a “milestone” (Snowden, 2012, p. 524). In a prefatory message to the supplement, Secretary of Health and Human Services Tommy G. Thompson summed up the situation:

Though *Mental Health: A Report of the Surgeon General* informed us that there are effective treatments available for most disorders, Americans do not share equally in the best that science has to offer. Through the process of conducting his comprehensive scientific review... and with recognition that mental illnesses are real, disabling conditions affecting all populations regardless of race or ethnicity, the Surgeon General has determined that disparities in mental health services exist for racial and ethnic minorities, and thus, mental illnesses exact a greater toll on their overall health and productivity. (p. iii)

To address the disparities in mental health among America’s minority populations, we need to know how minorities communicate about mental health.

A 2002 report from the Institute of Medicine citing “clear evidence from the Centers for Disease Control and Prevention, the National Institutes of Health, the Institute of Medicine and other agencies” on ethnic health disparities stated: “Given the likely growth in diversity, communication interventions to affect health behavior are an increasingly important strategy for improving the health of the American people” (Institute of Medicine, 2002, p.1).

Effective interventions must be tailored to the current reality of the community (“formative research” as cited in Noar, 2006, p. 25). To date, there is a dearth of academic

research on patterns of communication in the African American community on the subject of mental health. The goal of the present research is to start the formative research process to understand the “behavior and the problem area” (Noar, 2006, p. 25) by executing and analyzing 11 in-depth interviews with African-American community leaders in Richmond, Va. on the topic of mental health and mental illness, in the hope that understanding the community’s patterns of communication on this topic will assist practitioners and policy personnel in designing and carrying out effective interventions to better the mental health of the overall community.

Literature Review

American Health and Health Communication

In the United States, the health care and social assistance field is bigger (by number of employees-- 18.6 million) than any other economic sector (Census, 2014). The U.S. spent \$2.5 trillion (17.6% of gross domestic product) on health care in 2010 (Atkinson, Lozano, Naghavi, Vos, Whiteford and Murray, 2013). Accompanying this extensive expenditure is a robust body of scholarship on health communication.

Health communication is “one of the fastest growing and pragmatic areas of research in the communication discipline” (Wright, O’Hair and Sparks, 2013, p. 3). In a 1998 book chapter, Kreps describes it as having developed over the last 25 years, but cites foundational texts dating back to 1953. The Health Communication Division of the International Communication Association claims 568 members in 34 countries at more than 169 institutions (“Health Communication,” 2014).

Despite the expenditure and the scholarship, at any point in time, approximately 20% (some estimates are as high as 30%) of Americans have a diagnosed mental illness, but only half of them seek help in the health sector (HHS, 1999; Kessler, Chiu, Demler and Walters, 2005). The disability adjusted life-years (DALYs) lost due to mental disorders increased 13% from 1990 to 2010 (Atkinson, Lozano, Naghavi, Vos, Whiteford and Murray, 2013). The National Alliance on Mental Illness estimates that depression alone has American workplace costs of \$34 billion a year, and that suicide—a risk of un- or under-treated depression—is the 11th leading cause of death in the U.S., taking 30,000 lives a year (NAMI, 2014). Schizophrenia and bipolar disorder, often considered the other “serious” mental health disorders, are not even in this calculation.

African American Mental Health

Mental illness occurs in the Black community at the same rate that it does in the population overall, but most researchers have found that African Americans, because of the stressful situations under which many of them live (in particular those in urban centers), come to doctors' offices sicker than European Americans (Robins and Regier, 1991; Williams and Earl, 2007; Riolo, Nguyen, Greden and King, 2005; APA, 2009). The latest research, by Lo, Cheng and Howell (2014), found that chronic mental illness is significantly more prevalent among Blacks than Whites.

Blacks use mental health services less often than Whites and are more likely to discontinue use of services sooner once begun (Sue, 1977; Neighbors et al., 2007; Obase and Leong, 2009; Lo, Cheng and Howell 2014). Wells, Klap, Koike and Sherbourne (2001) found greater "unmet need" for mental health care in the African American community in a national survey (p. 2027). Fiscella, Franks, Doescher and Saver (2002) found that even among the insured, African Americans have only one-third the use of mental health services of the overall population. Angold, Erkanli, Farmer, Fairbank, Burns, Keeler and Costello (2002) found that rural Black and White youth were equally likely to have psychiatric disorders, but Blacks were half as likely to seek mental health services. Alegria et al. (2008) found that in a national sample, Blacks diagnosed with depression were almost 20 percentage points more likely than Whites to have not accessed any mental health treatment in the past year.

American Communication about Mental Health

How individuals talk about their mental health is particularly important because, as the Surgeon General's *Mental Health* supplement (2001) points out, "a patient's description of the nature, intensity and duration of symptoms" is one of the three elements of a clinician's

diagnosing procedure (DHHS, p. 10). Helping professionals must rely on patients' own communications for information to use in diagnosis and treatment , so the nature of that communication is important. "The diagnosis of a mental disorder is arguably more difficult than diagnoses in other areas of medicine and health because there are usually no definitive lesions (pathological abnormalities) or laboratory tests." (DHHS, p. 10)

Despite the extensive communications literature on health, a vigorous search did not find much communications literature on the way that Americans talk about *mental* health, in general. Communications articles seem to deal with promoting mental health, not the conversation we have about it in the absence of a campaign (Weber and Backer, 2013; Clark-Hitt, Smith and Broderick, 2012; Egbert, Muraldi and Murniadi, 2014). Or, they talk about the role of communication in maintaining mental health (Fisher, Goldsmith, Harrison, Hoffner, Segrin, Wright et al., 2012). Or, they talk about how providers should communicate with mentally ill people (Iezzoni, Ramanan and Lee, 2006). This research is concerned with an American community's baseline state of communications *about* mental health.

A Substance Abuse and Mental Health Services Administration document, "Community Conversations About Mental Health: Information Brief" (2013) cites longitudinal research showing that while much has been learned about mental health and the "causes of mental illness over the last several decades, negative beliefs about people with mental illnesses continue to grow" (p. 6). The presence of such negative beliefs is so established that President Barack Obama ordered then-Secretary of Health and Human Services Kathleen Sebelius to work on reducing "negative attitudes toward people with mental illness" (HHS, 2013, p. 1). The phenomenon of such negative attitudes is known as stigma (Smith, 2007, p. 464).

Smith (2007) points out that “stigmas rely on communication,” so it is worth looking at the literature on mental health stigma for indications of how Americans are communicating about mental health (p. 466). There is a robust psychiatric literature on the stigma against the mentally ill and even against mental health concerns (e.g. HHS, 1999; Hinshaw, 2007; Wahl, 1995; Penn and Corrigan, 2002; Corrigan, 2005). But the communications community has been less attentive.

Health and social work scholars Parcesepe and Cabassa (2012) conducted a systematic literature review of 36 articles on the stigma of mental illness in the U.S. and found that stigma against the mentally ill does indeed continue to grow. Americans were 2.3 times more likely to describe a mentally ill person as violent in 1996 as in 1950. Desired social distance from the mentally ill increased, although attitudes toward seeking help have improved over time.

African American Communication about Mental Health

As stated earlier, African Americans have a normal incidence of mental illness but are less likely to access mental health services. Any effort to reverse these trends must be designed with an understanding of how Blacks talk about mental health, in order to better serve them and to design more effective health interventions. But a search of the terms “African American” and “mental health” on the EBSCO Communications and Mass Media Complete database—which indexes more than 400 journal titles—brings up just 20 citations. Only one is specifically about mental health: “Race, Risk and Pathology in Psychiatric Culture: Disease Awareness Campaigns as Governmental Rhetoric” (Thornton 2010), which discusses more about government- and Big Pharma-funded campaigns than about how Blacks talk about mental health.

Some anthropological literature has reported an “ethnically specific presentation of mental disorder and distress in African Americans” (Heurtin-Roberts, Snowden and Miller,

1997, p. 340), but although that article attempted to link those “idioms of distress” (p. 356) to categories in the then-current American Psychological Association’s Diagnostic and Statistical Manual, 3rd edition (the oft-called “bible” that contains descriptions, diagnoses and courses of treatment for all of the mental illnesses currently recognized by the profession, known as the DSM-III), there is very little other literature bridging the two modes of communication.

The medical and psychiatric literature following the Surgeon General’s 2001 supplement emphasized the concept of *cultural competence*. Sue (1998) defines it as “the belief that people should not only appreciate and recognize other cultural groups but be able to effectively work with them” (p.440). However, this article mentions “communication” only once. The APA PsycNet search for “cultural competence” and “communication” yields one citation, which mentions “communication” 9 times but never actually discusses how providers or patients demonstrate it.

Nonetheless, in the face of America’s demonstrated ethnic health disparities, cultural competence has grown to a major concern for the psychological and psychiatric professions (Adebimpe, 2004; Kirmayer, 2012). One way the professions have tried to address this issue is in the DSM-IV’s Outline for Cultural Formulation and the DSM-5’s Cultural Formulation Interview (CFI; Aggarwal, Nicasio, DeSilva, Boiler and Lewis-Fernandez, 2013). The CFI contains questions such as

“Sometimes people use particular words or phrases to talk about their problems.

Is there a specific term or expression that describes your problem? What is it?”

Clinicians are instructed to substitute this patient idiom for every question that

includes the word ‘problem.’” This is one example of the CFI’s attempt to

introduce medical anthropological theories into clinical practice.” (p. 507)

Yet “lack of buy-in” and “over-standardization” (p. 505) were two of the barriers to CFI usage Aggarwal et al. (2013) found among patients. Among clinicians, barriers included “lack of conceptual relevance between intervention and problem,” and “lack of clinician buy-in.” These findings, and the ongoing dearth of African Americans in providers’ offices, suggest that the concern continues.

“Broaching” is the term used to define the process of introducing/considering “sociopolitical factors such as race” in the counseling space (Day-Vines, et al., 2007, p. 401). But a search of “broaching” and “race” on PubMed Central, PsychiatryOnline, APA PsycNet and EBSCO’s Psychology and Behavioral Sciences collection found a total of 11 citations (unduplicated) on the topic. Works such as Cornish, Schreier, Nadkarni, Metzger and Rodolfa’s 2010 text, *Handbook of Multicultural Competencies* say more about what should happen in the clinical setting, but don’t much address the community’s patterns of communications outside of the clinic. It seems that there is room for further scholarship, especially in the communications field.

Neighbors et al., in a 2007 study based on more responses from more than 5,000 African Americans and Caribbean Americans, concluded that communications on both sides of the patient-provider interface needed improvement:

Mental health professionals must incorporate knowledge about ethnic differences in idioms of distress and how to overcome feelings of mistrust into their therapeutic approach. Mental health educational programs must facilitate, among Black consumers, the recognition and definition of symptom clusters that need to be treated by mental health care professionals. (p. 493)

The Health and Human Services supplement on mental health in America's ethnic communities (2001) recognized that, based on "historical and contemporary negative treatment," many Black Americans do not trust medical authorities, "many of whom are not seen as having the best interests of African Americans in mind" (p. 57). This lack of trust raises questions about the validity, efficacy and legitimacy of instruments designed for the overall population. "If African Americans do not disclose symptoms as readily as other groups, for example, or if they present their symptoms in a distinctive manner, then attempts to accurately assess African American mental illness will suffer" (p. 58). Clark (2004), a Black psychiatrist who helped establish the Black Focus Program, a mental health program at San Francisco General Hospital, wrote that for disparities to be addressed in such programs, "clear communication," was one of the "essential" program elements (p. 556). However, the literature on more than 40 years of research on help-seeking is clear: African-Americans are less likely to avail themselves of mental health help than are members of the American population as a whole, and more likely to discontinue treatment once begun (Sue, 1977; Neighbors et al., 2007; Obasi and Leong, 2009).

There is research that indicates that the disparity in mental health care is not due to a preconceived dislike for professional help. Diala, Muntaner, Walrath, Nickerson, LaVeist and Leaf (2000) found that "African Americans were more likely than Whites in the general population to report positive attitudes towards seeking professional care" (p. 458)—before they used mental health services.

They were also more predisposed to seek care if they had serious emotional problems, to feel comfortable talking about personal problems with a professional, and to be less embarrassed about friends knowing they were seeking professional help for emotional problems" (p. 458).

During and after use of mental health services, however, these attitudes switched.

“Among users (of mental health services), African Americans were more likely than Whites to report negative attitudes, and less likely to return to (services) if their illness persisted” (p. 458). One may infer that some aspect of the clinical encounter was unsatisfactory to a majority of the African Americans surveyed, although this study did not specify communication as a problem. (This is particularly unfortunate, as 2014 Dutch research indicates that while there is a difference between Whites and non-Whites in the use of psychotherapy, there are no differences in its effectiveness once used [Unlu Ince, 2014].)

Copeland (2006), discussing African American adolescent mental health in particular, said improved provider communication skills could facilitate trust, demonstrate modeling, and increase the likelihood of continued treatment. She referred to the desire of many African Americans to see a same-race practitioner; she and Clark (2004) pointed out the dearth of African American mental health practitioners as a reason why majority practitioners need a thorough understanding of the African American socio-cultural context when treating these patients.

So racial and ethnic diversity seem to be an issue in the mental health community, and communications among racially and ethnically diverse peoples on this topic are an issue. Furthermore, in the African American community, such conversation that takes place outside of a doctor’s office is particularly important. Neighbors and Jackson (1984) found that in the Black community most people seek only informal help (43%) when confronted with a problem, or a mix of formal and informal help (44%). “Only 4.3% enter directly into the professional system without informal consultation.” (p. 633). Therefore, it is evident that the conversation that takes

place about mental health within the community, outside of helping institutions such as doctor's offices, is extremely important.

Mental Health First Aid

In 2001, Jorm and Kitchener (2011) introduced a program designed to facilitate and support such community conversations about mental health. The program, entitled Mental Health First Aid, is “an adult public education program designed to improve participants’ knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing one or more acute mental health crises... or are in the early stages of one or more chronic mental health problems.” (SAMHSA pdf, 2013, p.1)

“Participants are taught a five-step action plan, known as ALGEE...:

A - Assess for risk of suicide or harm

L – Listen nonjudgmentally

G – Give reassurance and information

E – Encourage appropriate professional help

E – Encourage self-help and other support strategies” (Jorm, 2012, p.231)

Conclusions from the Literature

Anywhere from one-fifth to almost one-third of Americans are believed to suffer from a mental illness at any point in time, but only half of them seek help in the health sector. African Americans are just as likely to have such an illness, but only one-third as likely to seek mental health services, even when insured at the same rate (Fiscella, Franks, Doescher and Saver, 2002). This means a great deal of distress is going unaddressed in the African American community. Despite a large and growing body of work in the field of health communications, there is a dearth

of literature on how African Americans communicate about mental health. Such work would be the precursor to any campaign to increase Black use of mental health services, which seems a logical objective in the face of a national goal of greater health overall. Also, unlike diagnosing somatic illness, diagnosing mental illness usually depends to some degree on the patient's verbal self-report, so understanding how African Americans speak about mental illness could be a key to greater mental wellness. There is established literature on mental health clinicians' best practices in addressing African Americans, but little on how African Americans talk about mental health clinics.

This study reached out to 21 African American community leaders involved in mental health in Richmond, Virginia, to find answers to two questions:

Research question 1: How do neighborhood leaders of an urban African American community perceive communication on the topic of mental health among their neighbors?

Research question 2: Given basic accurate information on the topic of mental health, what kinds of choices do neighborhood leaders make in the sharing of this information?

Method

The preceding sections have shown a disparity between estimated African American need for mental health services and African American use of same, and relatively little literature about how African Americans talk about mental health and illness. Therefore, it seems reasonable to first ask: What is the tenor of communication about mental health and illness in that community? Because in many instances this inquiry could involve talking to patients, a protected population, the current study opts instead to ask with RQ1: How do neighborhood leaders of an urban African American community perceive communication on the topic of mental health among their neighbors? Thompson, Dancy, Wiley, Perry and Najdowski (2011) say that much of the information available about the African American experience of mental health services “comes from a researcher-driven quantitative perspective” (p. 678). Partly to address this concern, the present research employs qualitative interviews of African American community leaders with some basic mental health training. Out of that training comes RQ2: Given basic accurate information on the topic of mental health, what kinds of choices do neighborhood leaders make in the sharing of this information?

“In qualitative interviewing, the researcher is explicitly seeking to gain access to the knowledge, experience and perspectives” of participants (Kelly, 2010, p. 309). This research sought the knowledge, experience and perspective of representative members of an urban African American community on how they communicate about mental health.

Kirmayer (2012) writes that although randomized clinical trials in evidence-based practice are considered a “gold standard” in medicine, they are necessary but not sufficient to “capture crucial elements” of knowing about the patient experience (p. 250, 254). In accordance

with Kirmayer's and Kelly's observations, the research method was an ethnographic/journalistic interview with 11 volunteers from the pool of MHFA trainees. (See Appendix for a copy of the interview script, including questions.)

In February 2014, Virginia Commonwealth University's Center on Society and Health, in its work with Engaging Richmond and Richmond Promise Neighborhoods, brought the Mental Health First Aid (MHFA) training to 21 community leaders in the East End of Richmond, Virginia. The East End is generally encompassed by the zip code 23223. African-Americans comprise 81.9% of the 23223 population (U.S. Census Bureau, 2010). The median household income is \$36,768, with 29.2% of residents under the federal poverty level (U.S. Census Bureau, 2012). The district contains four public housing projects. It is generally considered a low-income inner-city African-American neighborhood, or community. The latest unemployment rate for the East End zip code was estimated at 12.9% (U.S. Census Bureau, 2012), compared to 6.5% for all of Richmond in May 2014 and 5.4% for the state of Virginia in June 2014 (Virginia Labor Market Information, 2014).

Participants had been invited to the MHFA training based on their associations with Richmond's 7th District Health and Wellness Initiative (a city-led, grant-funded collaborative effort to improve health outcomes for residents of Richmond's 7th District, which includes the East End); the Richmond City Health District Resource Centers (five community-based points of entry into the healthcare system); or tenant councils for the public housing projects in the area (J. Williams, personal communication, May 23, 2014; Virginia Department of Health, n.d.; Dumenci, 2014). Through their ongoing involvement with these organizations, participants showed themselves as leaders in their communities. This status was confirmed by the participants during their interviews.

The interview script was reviewed by representatives from the Richmond Promise Neighborhood Health and Wellness Results-Based Action Team and edited to respond to their concerns and suggestions. The resulting 12-question document and interview protocol were approved by Virginia Commonwealth University's Institutional Review Board process. Ten interviews of 11 people, averaging 33 minutes long, took place between July 3 and 15, 2014. In 10 cases a preliminary email was sent and the actual appointment was made during a follow-up phone call. (In the 11th case, when the interviewer arrived for an appointment, another Mental Health First Aid trainee was in the office and agreed to be jointly interviewed after reviewing the protocol.) Each of the 10 scheduled participants chose the location of her interview, which in all cases were in the East End. Some took place in homes and some in offices or agencies in which participants worked or did volunteer work. All of the participants spent substantial portions, if not the majority, of their time in the East End. All of the participants were African-American women. Each participant selected a pseudonym to be used to preserve participant confidentiality.

I transcribed all the interviews, correcting grammar in some places. (This was approved by the liaison to the community advisory board.) The resulting transcriptions ran to 116 double-spaced pages.

Participants referred to "the community," "the neighborhood," or "the 'hood'" interchangeably; it was understood to be Black and low-income and to either be the specific housing project under discussion or the entire East End.

I had some interest in finding out if communications on mental health changed at all with age, particularly in the digital space. I received community feedback that asking the participants

their ages might be off-putting to them, so I settled for asking if they were over or under 40 years of age.

In pseudonym alphabetical order, the participants were (with their age ranges):

Alyssa – a housing project resident, mother and grandmother and community worker, over 40

Destiny – a community worker (40)

Dorothy – a housing project resident, mother and community volunteer (over 40)

Genevieve – a neighborhood resident, mother and community worker (over 40)

Jada – a housing project resident, mother and community worker (over 40)

Kayla – a housing project resident diagnosed with bipolar disorder, mother of a son diagnosed with bipolar disorder, and community volunteer (under 40)

Michelle – a housing project resident, mother, community volunteer and worker (40)

Olivia – a community worker (under 40)

Ruth – a housing project resident, mother, grandmother, community volunteer and school worker (over 40)

Samantha – a housing project resident, mother, community volunteer and worker (under 40)

Tasha – a housing project resident, mother, community volunteer and worker (under 40)

Jada and Tasha were interviewed together; I interviewed all of the other participants one-on-one. Quotations henceforth, unless otherwise cited, are actual quotes from participants and “in vivo” perspectives.

While I was curious to see if levels of formal schooling completed would correlate to attitudes about and patterns of communication about mental health and illness, I was advised by

the Richmond Promise team that this also was an off-putting question for many community members, particularly coming from a university-affiliated researcher. So I did not ask.

The approach to analyzing the transcripts is based in part on Grounded Theory, although not completely delineated thereby (Lindlof and Taylor, 2011). In particular, the codes emerged from the data and I then assembled them into concepts.

Findings

The East End neighborhoods where the interviews took place are not prosperous and don't look it. Streets and sidewalks are not in the best repair. Buses ply the streets, some of which seem a little narrow for that kind of traffic. Many (not most, but a noticeable number) houses are vacant and boarded up; some occupied houses look old, shabby or in need of repair. There are not a lot of store options, and those that are there sell a lot of fried things. You can smell it.

The public housing blocks have a drab sort of uniformity. Some residents have beautiful flowers in their tiny front yards, but those stand out as an exception. I visited in July; residents often had window air-conditioners running at full blast, because the units were built without central air conditioning. The insides of the two-story units are cinderblock. Residents have painted them, but they're still cinderblock. The on-site clinics are often in housing units that have been re-purposed, so they're cinderblock, too. People try to make their units welcoming, but there's not a lot you can do with cinderblock on a tight budget.

I saw storefront and purpose-built churches, and schools and corner stores and payday loan places. I didn't see any banks or supermarkets. In a neighborhood like this, where I lived until I was 6, the prices in the corner stores went up on the first and the 15th of every month, because that was when people got food stamps. According to the Census Bureau (2012), the unemployment rate for the area is 12.9%, compared to 6.5% for the whole city of Richmond and 5.4% for the state of Virginia (Virginia Labor Market Information, 2014).

I talked with women who were active in their communities, aware that their communities were struggling but not giving in to despair or hardship. Most were mothers, all were caretakers of one kind or another.

Samantha, my first interviewee, opened the door to me on a very hot day and, on a casual remark about the heat, offered me a welcome bottle of frozen water. Her three children greeted me politely and went back to their television screen. After a while, the youngest one wandered into the kitchen to check out the stranger. He was fascinated with my digital recorder.

Samantha (and Olivia, in her later interview) provided general background that the Engaging Richmond research team’s 2012 work had, in Samantha’s words, “found out that there was a stigma around mental health,” and the interview responses bore this out in full. See Table 1 for a summary of themes (grouped into axial codes) that emerged from the data.

Table 1. Summary of Themes

Theme	Code type	Theme type	Description
<i>How participants refer to mental health issues</i>	<i>Axial</i>		<i>Participants’ perception of community conversation on topic (RQ1):</i>
“We don’t talk about it”	Open	In vivo	Mental health simply not discussed
“Crazy”	Open	In vivo	Mental health as insult/curse/label
“A joke”	Open	In vivo	Mental health issues dismissed with humor
“I ain’t crazy!”	Open	In vivo	Crazy vs. sane: no mental health continuum
“A hustle”	Open	In vivo	Mental illness as a fraudulent money-maker
<i>Pre-requisites and strategies</i>	<i>Axial</i>		<i>Participants’ decisions in communicating on mental health/with persons perceived to be mentally ill (RQ2):</i>
“You have to keep them calm”	Open	In vivo	Important strategy for effective mental health communication
“Non-verbal cues”	Open	In vivo	Important to notice for effective mental health communication
“Listen fully and completely”	Open	In vivo	Important strategy for effective mental health communication
“Safe space”	Open	In vivo	Important pre-requisite for effective mental health communication
“Non-judgmental listening”	Open	In vivo	Important strategy for effective mental health communication
“Don’t be dismissive”	Open	In vivo	Important strategy for effective mental health communication

Theme	Code type	Theme type	Description
<i>Pre-requisites and strategies (cont.)</i>	<i>Axial</i>		<i>Participants' decisions in communicating on mental health/with persons perceived to be mentally ill (RQ2, cont.):</i>
“Accessible and available”	Open	In vivo	Important pre-requisite for effective mental health communication
“Common humanity”	Open	In vivo	Important attribute of effective mental health communication
“Get specific”	Open	In vivo	Important suggested strategy for effective mental health communication
<i>Observations</i>	<i>Axial</i>		<i>Observed characteristics of community conversation on mental health</i>
One New Idiom	Open	Etic	Little new vocabulary in community's mental health communication
“More training”	Open	In vivo	Highly desired by participants
Spirituality	Open	Etic	Understood to be important in community, but not much mentioned in the data
“Children”	Open	In vivo	Topic of concern in community's mental health
“Meds”	Open	In vivo	Topic of concern; participants greatly concerned about overuse
“Insufficient access to care”	Open	In vivo	Topic of concern; major barrier to improved mental health
Minimal Use of Digital	Open	Etic	Some participants use technology, but almost none to talk about mental health
“Written is different”	Open	In vivo	Participants see community members request mental health in writing, not face-to-face

How participants refer to mental health issues

“We don't talk about it”

Michelle, a public housing resident, mother and community volunteer, summed up all the participants' understanding when she said:

In my opinion [community members] don't talk about [mental health] at all, or very little. Most people don't believe that they have mental health concerns, because they don't know what good mental health really is. So they consider [any dysfunction] a normal for the issues that they have.

Ruth, a resident, local school worker and public housing volunteer, was even more blunt: “Black people don’t like to talk about things like [mental health].” Indeed, during the interview, after a good 10 minutes discussing Ruth’s current caretaking of two people with substance abuse issues, she said she had not recently talked to anyone about mental health. When I reminded her that substance abuse was a mental health issue, she responded, “When you sit down and rationalize it, that’s exactly what it is.” But later in the interview, she said of community discussions, “We just can’t talk about mental health.” Even to ask someone about their mental health (in those words), Tasha said, “is like cussing at somebody.”

Interview responses also reflected an a priori African American understanding that “we don’t discuss this.” Jada observed: “It was amongst a lot of Black families that we don’t go to a stranger or talk to anyone. You keep everything inside when you’re raised in the ‘hood.”

Destiny commented:

A lot of times what I’ve seen in the community as well as just growing up, when you have that person in your family that’s (*air quotes*) different from somebody else, you know, or Uncle Larry who sits in the bedroom with the door closed by himself and somebody’s just taking him a plate. They kind of don’t want to talk about that part....“What goes on in this house stays in this house,”-type of thing.

Samantha said: “As an African-American woman I was told, ‘Oh, we get over it, you got two kids, I had six and I did this.’”

“Crazy”

Samantha, also a mother and a public housing resident; Jada, a resident and public housing worker; Genevieve, a public housing worker; Tasha, a public housing resident and community advocate; and Ruth, all stated that when mental health is part of discussions in the

community, it was most often personalized as an insult or a joke with the standard statement: “So-and-so is/must be crazy.”

Ruth, Jada and Tasha all said that members of the community are highly sensitive to being labeled anything, but particularly “crazy.” Jada said:

To give you an example, I live in the housing projects, so they already say I don’t have anything, because a lot of people treat people who live in the housing—I don’t even use “projects” anymore, I say community, low-income community. People assume you have nothing. OK, I get food stamps, so a lot of other people from the outside prey on these young ladies and for me to go through depression, it’s because I feel I want to get out of here or if I want to do something else, or because I’m stuck here in the house all the time, I need someone to talk to, and if I talk to somebody, they’re going to pick with me. There are groups that hang [out] in the housing community. You have your mean girls, you have your popularity, you have your bullying. So bullying comes in different shapes and different [masks?], so you don’t want anyone to know this so they keep it to themselves not to be labeled.

Ruth: “Some people don’t like name-calling. That triggers some people. The name-calling, that’s a problem.”

Jada said, in the interview with Tasha: “They’ll call you crazy, they’ll call you retarded--” and Tasha interrupted with: “They’ll call you every name in the book.”

Destiny: “[Mental health] is something that’s not talked about because people don’t want to be deemed as ‘crazy.’ ... If you were going to see (*in dramatic voice*), a shrink, that’s a *bad thing*.”

Dorothy said:

Oh, it's awful. [The community] literally think [people with mental health issues] are just trash. They're no good, they're crazy, stupid. People call them all types of names that really don't have the education as to what their mental health issues are."

Samantha spoke about her personal experience: "The word 'crazy'... kind of makes my skin crawl. That word didn't let me seek out professional help for a long time. 'Cause I didn't want to be labeled 'crazy.'"

"A joke"

"I used to treat [mental health] like a joke," Tasha said, referring to the time before she took the Mental Health First Aid training. "I think that in my community when we talk about mental health or mental illness it's in a joking manner," Samantha said, continuing:

...We would never say, "Oh, here she comes with her diabetic self again," or, "Here he goes with his cancer." We don't say things like that when it's a physical health problem, but it's something about mental health, it's so easy to joke, "Oh, he's so bipolar."

An existing, comfortable relationship can soften the epithet to the level of a joke, but "crazy" as a mental health state is not considered a condition that requires assistance in the way that, say, diabetes does. Genevieve said:

We don't really talk about [mental health] in a way that makes it respected as something that requires assistance, something serious, or something that is not a joke, that has any real relevance, other than just to be talking about somebody. A lot of people don't realize that when people go through certain things, such as

losing a child, that requires something to be done. You can't just go to sleep and wake up the next day and everything's OK.

“I ain't crazy!”

Destiny and Olivia, both community workers, as well as Michelle, observed that there is a general understanding of mental health as a mutually exclusive duality, either/or; you're either crazy or you're sane. There is no understanding of a continuum or a sense of “getting better”; you're sick (crazy) or you're well (sane/normal). This also, in Olivia's perception, promotes an “us versus them,” well versus sick dichotomy:

We all have mental health. Do you have well mental health or do you not? And it may depend on the day. And I think we really need to spend time on defining that, so people can identify with it. And then I think once people can identify with it, they'll be able to relate more. So I think we have to get past the “us” and “them”; “I'm well, they're not.” And just understand that we all have some form of mental health and where are you at on that chart. Just to identify with people.

Destiny agreed:

It's no in-between. Nobody is actually asking, “What can I do to help?” Either they want to deal with it in the wrong way, or they don't want to deal with it at all. People are stuck with that word, “crazy.” And “crazy” is a bad thing to be.

Asked what kinds of word people use when discussing mental health issues, Ruth immediately mimicked a dialogue partner: “I ain't crazy!”

“A hustle”

Destiny, Jada and Tasha were all aware that in some cases, individuals in the community seek diagnoses either to get medication for what Jada described as “recreational” purposes, or in

order to support a disability claim and qualify for payments. Destiny described the latter as:

“Basically, what I’ve heard is, “I’m going to see if I can get a check because I’m bipolar,” or “I’m going to see if I can get my kids some medication so they can get a check.” It’s a hustle.

Pre-requisites and strategies

“You have to keep them calm”

Alyssa, a public housing resident and community volunteer, described waiting with a bipolar neighbor for an ambulance to arrive for the neighbor’s younger son, who needed stitches in his head after being attacked by an older son, who was also bipolar and who was standing in the street profanely challenging police to shoot him. “I was over there going, ‘Come on, come on, come on,’ And I had to show her where the other child’s head wasn’t busted that badly... ‘He’s living. Look, he’s living.’ ...Just getting her calm, to sit back...”

Kayla described holding her nine-year-old bipolar son safely in restraint as he raged with epithets and verbal abuse while they waited for an ambulance to arrive for him. “I was able to use a lot of [the Mental Health First Aid training] to remain calm [in the face of] the rage and the aggression that he was going through at that point, the homicidal things that were going on.”

Michelle talked of calming a highly agitated neighbor out of an anxiety attack into a calmer space, where she could come up with solutions for her dilemmas. “I was able to sit there with her and talk to her and just get her back to a calm state.”

“Non-verbal cues”

Destiny, Tasha, Jada, Olivia and Samantha all described the importance of observing non-verbal cues when talking and listening to people on the subject of mental health. Destiny described a client who said she needed food from the food pantry and some fibroid medication

but who burst into tears when asked “How can I help you?” in private. It turned out the woman had stopped taking her mental health medication, needed more, and didn’t know how to get any:

“Those tears let me know there was a whole lot more going on other than [fibroid] medication.”

Tasha and Jada described using non-verbal cues to manage interactions with a community resident who was alcoholic and schizophrenic. Tasha said:

But after taking the class and dealing with him, it opened my eyes to a lot of different things. ‘Cause half the time I just thought that he [unintelligible], not knowing that something was really going on with him. It just opened my eyes to a lot of things, when it comes to certain people and certain things that they do.

Samantha described being called to a neighbor’s house and being able to tell that a situation was serious by observing the neighbor’s body language. And Olivia did the same with a client at her job.

“Listen fully and completely”

As Michelle put it, “Sometimes you go and you just talk to people to chit-chat,” but she said that, in the case of dealing with her neighbor after the training, “I actually *listen* now. Versus before when she used to go off a little bit, it used to be like just how you placate a child by changing the subject... Now I actually listen.” Destiny observed that it was also valuable in some instances to “give [people] the chance to talk because sometimes people just need you as a sounding board. They don’t really need you to talk back to them, they just need to be heard.”

Ruth said she had found the same both within her community, where she is well-known, and on trips outside, where sometimes people are happy to open up to a complete stranger.

Samantha found that listening in her family was especially important. As a result of her experiences and training, she says she now asks her son,

“How was school? What happened? What did you all talk about? How do you feel? When he’s upset, I just get him to tell me how his emotions are, and say, ‘If you’re upset, if you want to cry, it’s OK, you’re a boy but it’s still OK to cry.’ I feel as though if you don’t debrief, and let that go, you internalize it... then you have those [negative] conversations in your head over and over again.”

Destiny, Ruth and Samantha all specifically mentioned giving dialogue partners their “undivided attention”: “I’m giving you my undivided attention because I need to let you know how important you are to me,” Destiny said.

“Safe space”

Dorothy acknowledged that mental health conversations can be “uncomfortable” if they take place with previously unknown parties. Genevieve went further, saying that conversations had to take place in a “safe space” in which “everybody’s got to be respected, or they can’t be in the group.” Destiny emphasized the need for privacy by mentioning she used to have a cubicle but requested an office with a door that shuts specifically to facilitate private conversations. Genevieve said:

If we’re talking about this particular type of community, in an urban inner city, public housing, something like that, there needs to be a safe place. Because a lot of things are not talked about because of fear. Fear of other people talking about them, or fear of being judged, or fear of being isolated. Just basically fear. That stigma thing.

“Non-judgmental listening”

Kayla, Destiny and Samantha all cited the importance of non-judgmental listening as part

of the creation of a safe space. “Just because I feel as though this is something [you] should get over,” Samantha said, “that may not be the way you’re feeling... I have to listen non-judgmentally because that’s your issue, not mine.”

Destiny observed that even physical symptoms, such as sweating profusely or slurring words, can be misconstrued, and described a situation where a diabetic going into shock at her facility was misjudged a drunk. “You can’t just judge a book by its cover,” she said. “It’s not up to us to assume, it’s up to us to help, and if we don’t know what to do then call 911.”

“Don’t be dismissive”

One logical consequence of judging is dismissing; Ruth, Destiny, Jada, Tasha and Samantha all warned against that. Jada said,

Our famous phrase is ‘Get over it,’... Now I know that’s actually throwing more fuel onto the fire... because it takes them down more in a rut because no one is understanding, and they’re not really understanding... how to say it, which makes us not receive it.

Tasha agreed: “I can’t say, like Jada said, ‘Get over it,’ you know, ‘Come out of your world and come into our world;’ you can’t do that. You have to choose your words carefully when you talk to people. In her interview, Ruth agreed, saying: “Sometimes you’re like, *(sucking teeth)* Yeah, OK, whatever, you keep saying that.’ But I don’t do that anymore. I listen to what you say.” (Sucking one’s teeth makes a noise widely understood in Black culture to be dismissive.)

“Trust”

Destiny, Alyssa and Ruth all said, and several other participants implied, that the most effective mental health communication in the African-American community occurs in trusted

relationships. Samantha said: "...trusting people with your information, that could be one of the biggest reasons why people don't go out for help, is because they don't know what people are going to do with their information." Specifically of her interaction with a neighbor worried about her child, Samantha said:

Being as it was her kid, she didn't know exactly who to trust with that information, because in some neighborhoods, when you hear that Child Protective Services, you think they're going to come in and take your kid and do like you're a bad parent, when you just may need a little help.

Olivia, Michelle and Destiny all said that the development of trust affected their roles directing community members to resources. Destiny said:

I have my notebook full of agencies that I refer people to; I never refer a person to an agency sight unseen. There are doctor's offices and dentist's offices here in the East End on the bus line that I don't refer people to, because I wasn't treated kindly there. There are some places that I've never been to, and I still won't refer people there because I don't know what it looks like.

Olivia said interested members who took the training are now visiting service providers in an effort to develop those relationships.

Two participants, Alyssa and Ruth, are obviously trusted and respected maternal figures in their communities. Ruth observed, "I can correct [people's] kids and nobody will have a problem with that," an indication of great community respect. But she acknowledged that even she cannot launch into an inquiry on a person's mental health. She continued:

"Sometimes I'll laugh it off and say, well, maybe you need a psychiatrist, and they'll look at me, but I can say things. I can say things to them and they don't

get upset...[But] people don't talk to me about mental illness. And I'm pretty sure that some of them have those issues."

"Accessible and available"

Alyssa described herself as, "a porch person. I sit on my porch, and a lot of people come to me, and sit down and talk." Olivia said that the most effective part of her approach to mental health communication was her accessibility: "being approachable and comfortable enough for [people] to talk to, was probably the most significant thing." Destiny said likewise that her openness to a client was key to a successful interaction: "I was like, How can I help you? Let's talk. What's going on? Actually having a conversation with her. Asking open-ended questions instead of yes/no questions."

Destiny summed up that interaction by saying:

The whole time I was talking to her, I wasn't talking to her with my face frowned up like, What is that smell? I wasn't giving her what she was expecting or used to getting from other people. I gave her a 10 when she came through the door. She was a perfect 10 in my sight.

"Common humanity"

The idea that the community is in this together also emerged from the interviews. Olivia said:

Just understand that we all have some form of mental health and where are you at on that chart. Just to identify with people. It's something significant about being able to identify that allows you to connect, and then allows you to understand.

Destiny was also descriptive and prescriptive:

I was treating her like I would want to be treated if I was to go into a place for

services. I wasn't treating her like, "Oh, what do you want? I'm so much better than you," and looking down my nose at her. ...It's absolutely respect. Treating people with dignity. Treating people like they are human, like they are equally on the level with you. They're in the same boat with you. So why not be respectful? Or what I say, kind. It's absolutely respect.

"Get specific"

Genevieve echoed the 2007 study by Neighbors, et al., when she said during her interview:

Instead of just saying generally, "mental illness," say specific things that people might be able to relate to. Because people might think of depression as not a mental illness, or anxiety as not a mental illness. They might think, "I'm just a little blue today," or "I'm just a little anxious today." So maybe they need to have an identifiable word that they can glom onto and that goes into "Oh, they're dealing with anxiety and depression," or "They're dealing with being overwhelmed," or "They're dealing with overeating," or whatever it is, so that might be helpful to get more people willing to talk and come to things. I think it just needs to be named, for what they are. But it definitely needs to be talked about more. African Americans don't really talk about it very much.

Observations

One New Idiom

The literature of Heurtin-Roberts, Snowden and Miller (1997) on culturally specific idioms of distress prompted me to inquire about specific words or terms used in the community to describe mental health and illness. Specifically, question 9 asked participants: "When you are

listening to people (who haven't had the training), what words do they use to describe mental health issues?" Answers included: "crazy," "psycho," "schizo," "retarded," "special" and "slow." The only term I hadn't heard before was one Alyssa cited her bipolar neighbor as using, "to the left," as in, "You don't want me to go to the left!" (i.e., "go off," or "go crazy").

"More training"

During their interviews, Alyssa, Kayla, Olivia, Samantha, Ruth, Michelle and Destiny all specifically advocated for more mental health training. Alyssa felt that the need was not just African-American, as she cited the example of the (non-Black) policeman who had to confront the bipolar boy who dared the police to shoot him: "My heart went out to that officer...I was saying they need more training. I really think that's something good that everybody needs to be engaged in." But Kayla, Olivia, Samantha, Michelle and Destiny all made specific reference to "our community," or "people of color" when saying that they wanted more training and wanted to see more people take the training. Samantha in particular advocated for including mental health in school curricula:

I really think that mental wellness should be incorporated with physical education in school. Along with PE and getting your body physically together, I think that mental well-being and some kind of course should be in the schools right along with that, because we can physically feel good, but if our minds are not the same way that our body is, all that work is for nothing. I think that early education is best.

Michelle pointed out the dearth of this training currently: "I think that there are very few educational opportunities out there for our communities that show the positive versus the negative without there being stigma behind the negative."

Spirituality

There were relatively few references to church, religion, or spirituality. Ruth mentioned praying and being thankful, and said her son, who struggled with drug addiction, “loves church. He’s an usher in the church.” Dorothy described dealing with a schizophrenic young man whose mother went to “our church.” Jada was trying to help a young lady who volunteered at a church; she “asked her if there was someone at the church who could mentor her or listen to her, but she chooses me because she trusts me.” Genevieve suggested that mental illness needed to be discussed in church:

Maybe if they talk about it more in church? I can’t speak for every church, but I think in the Baptist church it’s more recognized that you can go and get some help and that doesn’t mean that you’re not following your religion, if you go get some mental help. I think maybe if churches talked more about it that would be helpful, to let them know that it’s not a stigma.

“Children”

There were strong statements by Alyssa, Ruth, Samantha, Jada and Tasha that children’s mental health is important and imperiled by the community’s mental health needs. Samantha said:

With kids and boys—as a mom, we want our boys to be tough. “Put your big boy pants on, don’t cry about this, you’re a guy, you know, don’t show your feelings.” And then you accompany that with a middle school-aged child who is going through puberty, don’t have control over their living, their clothes, whatever. They get picked on at school, and then you have a family that’s saying “Put your big boy pants on.” He can’t come home and tell his mom he’s being picked on

because of certain things in school. Then you have an angry grown man that can't express his feelings. So I think the younger people are that can get exposed to mental well-being and mental illness, the better off people will be.

Ruth described a young girl about whom she is concerned:

Some people have so much inner stuff in them that they don't know how to deal with it but in one way, and that's anger. There were kids like that at school—I work at the school. And you would not believe some of the anger that the kids have. And it all comes from home. It starts at home. I tell the teachers, “You've got to find out the source.” There was a little girl, she says, “*(Sucks teeth)* I'm a make my mama whip your hindpart.” ... She's always got her fists balled up, she's always ready to fight. She just jumped across the desk and just beat this boy. There's just something there, and if you all don't get her now, you're going to have hell to pay later. When she gets to be a teenager? Whew! I'm going to tell you, there's not going to be any stopping for her, because she wears this shirt—I don't know why her mother let her do that but—this shirt, and it's her uncle, and he got killed. And he's on the back of the shirt, and she's like, “Yeah. See that?” I'm like, “You see your attitude? And you see where your uncle is now, in heaven? That's where you're going to be if you don't change your attitude.”... If you've got to be that angry, something has got to be wrong somewhere. Eight, nine, ten, eleven years old, with that much hostility and anger in you? Something is wrong somewhere. It's got to be a mental something.

Tasha was strongly critical of young parents' parenting skills:

...It's more like little kids raising little kids. Because some of the ones who actually have kids haven't grown up themselves, to actually be able to raise the kids. [The moms] are still kids in their minds and a lot of the things that they'll do, they're still kids. So they're raising kids.

“Meds”

Ruth and especially Alyssa spoke strongly against the increasing use of pharmaceuticals to address all the community's mental health issues. Alyssa said:

I think sooner or later they'll come to the real problem, the real core of not medicating everything that's moving. Just like I told you about that little boy that basically roams the street? He was three, and taking at least 8 different medications.

Ruth said likewise:

I look at the news sometimes where people say, “Well he had a mental issue.” They don't address that. They send you home, give you some pills. I don't think they should do that. I think they should take the time. It's not all about writing a prescription.

“Insufficient access to care”

Destiny, Genevieve and Jada mentioned that long waits for admission to affordable mental healthcare were a deterrent to community members who, against the odds, sought it.

Genevieve personally took a client to an agency to see what would happen:

You went downstairs and you fill out papers and you waited for someone to do some sort of evaluation in a side room and after that person was finished, they went into another room... And it seemed like there was more of a waiting process

before they could really be committed to any program even on an outpatient basis. If they had an immediate need, if it wasn't suicide or some immediate danger to someone else, then it seemed like there was still a barrier. Either you didn't have insurance or—I don't know, it just seemed like there were barriers and people were not getting what they needed.

Interviewer: It sounds like you're saying that once the person makes up their mind that they want help, that it's important that they get that help right away.

Genevieve: Yes.

Minimal Use of Digital

Kayla, under 40, was the only participant to say she actively communicated online about mental health issues: "Because I'm a social media person. I stay online, being that I'm not from the area. The majority of my family and friends are not here, so we do keep in contact via text and Facebook, email." Other responses ranged from that of Genevieve and Ruth (both over 40), who said they "never" used digital on this topic, to Destiny's (under 40) answer:

Um, very limited as far as digital. Nothing with social media but some text messages and emails. I really don't care for text messages and emails. I'm more of an old school, pick up the phone and call me. I need to know what the tone of your voice is. ...If I get a bad vibe via email or text I'm going to pick up the phone. If it's fine, let me know it's fine. Let me hear that it's fine. In fact, let me come over and see what's going on.

"Written is different"

Genevieve, Jada and Tasha all mentioned that community members would willingly note their needs on a form; they just wouldn't speak them. Jada said:

[To talk about it is] kind of hard because of the label, here, so that's why we put it on a piece of paper. "Here, do you need any type of referrals to a medical doctor or mental health?" So when they check it in private, we would know, but for them to come and say, "I think something is wrong"—

Interviewer: So people literally can't sit there, face to face with you and say, "I have—"

Jada: No. They're afraid of being labeled.

Interviewer: They can write it? They can check off a box?

Jada: They can check off a box.

Interviewer: But they can't say it.

Jada: No, ma'am.

Tasha: If you ask them, they feel like you're cussing at them, in other words.

That's a word that you're not supposed to say to them, or for them to come and say it to you. But if you get them to write on a piece of paper and close it up, you'll have just about everything on there.

Summary

Most of the participants live in the East End of Richmond and all of them spend a great deal of time interacting with other people there, mostly Black people, mostly low-income. The direction of the data is strong and the data themselves are consistent and revealing.

In response to RQ1, "How do neighborhood leaders of an urban African American community perceive communication on the topic of mental health among their neighbors?," the data indicate African Americans in the East End of Richmond, VA—an urban community—do

not talk about mental health or illness, except with people they trust highly, in a physical and virtual space they deem safe.

In response to RQ 2, “Given basic accurate information on the topic of mental health, what kinds of choices do neighborhood leaders make in the sharing of this information?” the data indicate that leaders create a safe space; listen fully, completely and non-judgmentally; pay attention to non-verbal cues; maintain calm; and are accessible and available.

In the next section we will discuss the research questions more fully and examine some implications of these data.

Discussion

Eleven in-depth interviews with African American urban community leaders on the subject of mental health communication yielded vivid portraits of the treatment of a subject widely regarded as taboo. There are several implications for future health communication in this community.

RQ1 asks: “How do neighborhood leaders of an urban African American community perceive communication on the topic of mental health among their neighbors?” In considering this, the themes “We don’t talk about it,” “Crazy,” “A Joke,” “A hustle,” “I ain’t crazy,” “Safe space” and “Trust” emerged.

In the African American community as the participants conceive it, “crazy” is not a throwaway word or an imprecise statement of a condition; it is a label and an insult. The labeling aspect is sensitive to a race that has been pejoratively labeled nearly since its arrival in this country, and particularly sensitive to a community (urban low-income Blacks) that is widely seen as the poster child for all of society’s ills (see Jada’s reference to “they already say I don’t have anything”).

“Crazy” may be softened with humor, and understood to be humorous in the context of a trusted relationship. (See discussion of “Safe Space” below.) But when not leavened with humor, it is a label that, as Tasha said of a mental health inquiry, “is like cussing” (cursing) at somebody. Cursed people are outcasts in human societies, and this phenomenon contributes to the community’s well versus sick, us versus them dichotomy of conception of mental wellness as noted by Olivia. The outcast status of the perceived mentally ill, combined with the fear of being labeled, contributes to the intense stigma noted by the Engaging Richmond research team which

is evident throughout the data.

The community's 12.9% unemployment rate (double that of the city in which it resides and much higher than the Virginia statewide rate of 5.4%; Virginia Labor Market Information, 2014) says more than unemployment is high; it tells you that in this community, reputed to disdain work, *a lot of people still look for work*, because only people looking for work are counted in the unemployment rate. So it would seem that work is valued. I infer from this that people who “hustle”—a vernacular term that in this context means “get over,” akin in some respects to “cheat”—have lower status than people who work a legitimate job. The understanding that, for some people, being mentally ill is “a hustle” also seems to contribute to the stigma around and taboo status of mental health communication.

The references in the data to a need for “safe space” in which to talk about mental health issues imply that such conversations do not occur just anywhere with anybody. Besides the physical requirement of privacy referenced by Destiny, the notion of “safe” also seems to imply dialogue with a person who is accessible/available, as Olivia noted, and “safe” to talk to, or trusted. It is not sufficient for a conversation—Ruth provided evidence that she is widely trusted in her community but that people still do not talk about mental health with her. But trust is necessary, as Samantha pointed out.

I wondered at the study's outset if the key to effective mental health communication in this community was one of vocabulary. That is, perhaps Black people did speak on this topic, but just using words not (yet) common in American English. The famous orality of the African American community has led over the centuries to many colorful expressions in American English, but there is usually a lag in time for adoption. However, I did not find this to be the case. Out of 11 participants, only one used an idiom not currently widely used. This study had a

small number of participants, but the community population is approximately 47,000 (U.S. Census Bureau). It seems reasonable that if the disconnect between African-Americans and discussion of mental health issues were one of vocabulary, more community-used terms for mental health/illness would have come up. This implies that the taboo is an issue not of vocabulary, but of concept. That is, it's not that Black people use different words to talk about mental health; rather, it seems clear that Black people don't talk about mental health or illness because it's taboo.

The forbidden nature of the subject informs the importance of RQ2: "Given basic accurate information on the topic of mental health, what kinds of choices do neighborhood leaders make in the sharing of this information?" One immediate observation: it seems important that the group of people represented by the participants is supplied with accurate information (as the Mental Health First Aid training) because they are thought leaders within their community. If these people are misinformed, the community at large will be misinformed.

That said, the themes "Calm," "Non-verbal Cues," "Trust," "Listening," "Safe Space," "Non-judgmental Listening," "Don't Be Dismissive," "Accessibility," "Common Humanity," "Get Specific," "Minimal Use of Digital" and "Written Is Different" all emerged from the data when considered from the point of view of RQ2.

"Calm" was cited by nearly all the participants as a goal and a strategy of conversations about mental health and especially with people who actually are mentally ill. It may seem obvious, but the challenging nature of the situations described by Alyssa, Michelle, Kayla and others makes it clear that calmness is an explicit, deliberate strategy that seems to contribute to success, or effectiveness.

“Non-verbal Cues” is another such explicit factor in the success of mental health communication cited by nearly all the participants. It seems that, combined with the data from “Written Is Different,” “Safe Space” and “Trust,” the issue for the community is face-to-face verbal communication on this topic. This raises interesting questions regarding the most effective ways to distribute information on mental health and to manage mental healthcare. African Americans are, as previously mentioned, a famously oral community, but perhaps another vector is indicated for effective and private dissemination of mental health information. There could be major implications here for mobile phone app development, especially for younger patients. The data in “Minimal Use of Digital” seemed to imply that wellness checks that rely on the existing relationship between two people really need a conduit that allows emotional content. But I can conceive of a cost-effective app to check in on, say, recently released hospital patients with a yes/no text: Do you need/want a call from a counselor today? Conversation with emotional content could take place over the phone or on a video chat and be followed up by arrangements for a physical visit if deemed necessary.

“Trust,” “Safe Space,” “Non-judgmental Listening,” “Accessible,” “Don’t Be Dismissive” and “Common Humanity” are all related themes. The safe space is both physical, as Destiny noted, and virtual, in that it is accessible, bounded by trust, grounded by participants’ common human experience and contains non-judgmental listening and lack of dismissal.

“Get Specific” and “Common Humanity” are also related, in that Genevieve’s suggestion was to give community members “an identifiable word that they can glom onto” which acknowledges that, in Olivia’s words, “we all have mental health.”

Conclusions

In addressing the concerns raised by the Surgeon General's report (1999) and supplement to it on ethnic mental health (2001), it seems clear that there are two parts to the problem: one of demand for, and one of supply of, mental healthcare. Communication is an element of most importance (for now) on the demand side.

It seems clear that African American community members, as health care consumers, need to be educated as to the role that mental health plays in all our lives and what good and bad mental health look like. Olivia observed: "It's not just the person with schizophrenia, it's not just the person who's bipolar, but it's a continuum. It's part of your life." Michelle concurred: "I think it is very hard to explain to people what good and positive mental health is. Because they think that they already have that form of mental health." As Neighbors et al. said in their 2007 study, "Mental health educational programs must facilitate, among Black consumers, the recognition and definition of symptom clusters that need to be treated by mental health care professionals." (p. 493)

Given these findings, a national campaign targeted specifically at Black individuals and families from all walks of life needs to be designed and implemented. Such a campaign would likely take 10 to 20 years or more, but its value would be nearly incalculably high. Its prognosis might not be unlike the slow acceptance of gays and lesbians in American culture. (C.f. *Will and Grace*, one of the first primetime network series to star openly gay characters, premiered in 1998; courts in America are substantively supporting lesbian and gay marriage and there are openly gay athletes in the NFL and NBA in 2014 [IMDb, n.d.]) It takes a while to break a taboo.

Psychophysiological research could be used to test messages for maximum appeal. The campaign would need to take in every aspect of media today in the Black community: print

periodicals and books, television, radio, cable, Black media, social media, gaming. A national board with substantial private-sector funding and National Institutes of Health/National Institute of Mental Health imprimatur, and a deep roster of African American celebrity spokespeople would be essential. It was done for breast cancer; it can be done here—if the will is there.

The phrases “mental health” and “mental illness” do not appear in the index to Michelle Alexander’s much-discussed *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* (2010), but their footprints run throughout her arguments. Her thesis could be summarized as, “We have not ended racial caste in America; we have merely redesigned it” (p.2). Chapter 2 of her book focuses on the War on Drugs and its disproportionately destructive effect on the African American community. She writes: “Once swept into the [justice] system, one’s chances of ever being truly free are slim, often to the vanishing point” (p. 16-17).

If it is true that, as Ezra Klein and Evan Soltas write in an August 13, 2013 *Wonkblog* post at washingtonpost.com, “the single largest driver in the increase in the federal prison population since 1998 is longer sentences for drug offenders,” and “the most serious charge against 51 percent of [non-violent federal offender] inmates is a drug offense,” what could we achieve in the federal prisons with a different African American attitude towards mental health, which includes substance abuse treatment? Because the War on Drugs is fought at the local and state levels as well, what would our local jails and prisons look like with that changed attitude?

The 2012 National Survey on Drug Use and Health found that 11.3% of African Americans use illicit drugs. Jamie Fellner, senior counsel with Human Rights Watch and the author of “Race, Drugs, and Law Enforcement in the United States” in the 2009 Vol. 2 issue of the *Stanford Law and Policy Review*, was quoted in a 2013 Huffington Post article, “The police go into low-income minority neighborhoods and that’s where they make most of their drug

arrests” (Knafo, 2013). What would our jails and prisons look like if African Americans pursued mental health services at the same rate as the overall population, and were widely known to thusly pursue them?

If African American parents demanded counseling and therapy for their children who are placed in special education or who are disciplined for behavioral infractions, and if those services were more accessible and less pharmacological, might we have a smaller special education population of color? (See Codrington and Fairchild, 2012.) Would our dropout numbers shrink, and our test scores rise? Would we have greater post-secondary education participation, and a more productive economy?

It is beyond the scope of this current work to answer these questions. Indeed, those answers require a crystal ball. There are some good reasons why some African Americans do not feel comfortable in the American mental health system as it operates today. But the disinclination of the African American community to openly discuss mental illness and pursue mental health treatment, as the data presented here indicate, may be one of those reasons whose time to change has come.

Future research

While African American wealth is a fraction of European American wealth, there still exists a class structure within the African American community linked to (though not entirely determined by) possession of wealth. The participants interviewed here represent this project's access to self-selected members of a specific neighborhood with specific characteristics; it would be an overreach to extrapolate from this small number to all African Americans, even though the participants were all African American and unified in their opinions on some topics. It would be interesting to ask the same questions of a wealthier sample of African Americans to see if the taboos on discussing mental health are lessened by easier access to psychiatric care afforded by greater income.

No data were formally collected on levels of schooling completed by the participants, although some self-disclosed this information. There was at least one participant with a master's degree in social work in the group, and two participants were in the process of earning bachelor's degrees. It would likewise be interesting to see if a uniformly college-educated group of African Americans had the same taboos on discussing mental health, or if socialization lessened those taboos. Distinction by degrees from historically Black colleges and universities versus non-HBCU degrees might be enlightening.

Within "the neighborhood" as it is conceived by this project, questions remain. The current research seems to indicate a lack of community understanding of a mental wellness continuum. Consequently, "recovery" is not spoken of in this context. It is not clear whether the term is not used because it is not understood, or it is understood and believed to be invalid, or just not a thought people can think. This has major implications for conceptions of addiction and programs for treatment of substance abuse, and further research is warranted.

The us vs. them, well vs. sick, sane vs. crazy dichotomies end up leaving some of the community's most vulnerable residents outside of the community's care. But as participant Olivia observed, the community of the East End is highly interactive and values the care that it takes of members who are vulnerable, such as children, the elderly and the sick. This contradiction may mean the community does not see mental illness as an illness, per se. Further inquiry along this line could prove illuminating.

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Appendix

Interview script

Hi, *name*! It's good to meet you. Thank you so much for letting me interview you. The first thing I need to do is give you this information sheet about what we're doing today. As you can see, it says ... *go over information sheet, "Information for interviewees."*

So you can see it says I need to record this interview. I'm turning on the recorder.

Turn on recorder.

Do I have your permission to record this interview?

Participant responds.

Thank you for letting me record you. The next thing we need to do is pick an assumed name for you, to protect your privacy. I have a list of names here that you can pick from, or you can tell me what you'd like.

Participant selects name.

OK, *selected name*; I just want to tell you that there are no "right" answers here. I am really interested in what you, personally, have to say. Also, let me remind you that I'm not asking any questions about your health conditions, or anyone else's.

The first set of questions is about the Mental Health First Aid training.

1. Can you please tell me how you came to take the Mental Health First Aid (MHFA) training?
2. Did you know anything about mental health issues before you took the training? If you did, what kinds of things did you know?
3. Did the training use any terms that were new to you? If it did,
 - a. What were they?
 - b. Did the training explain those terms so you feel like you understand them?
 - c. Do you use those terms now when you talk to people?
4. Have you talked to or listened to anyone about mental health since you took the training?
If you have, please tell me about a recent example you feel comfortable sharing:
 - a. Without using names, who did you talk or listen to? (Like, a co-worker, a neighbor, a family member, etc.)
 - b. Who brought up mental health?
 - c. Did this feel like an everyday conversation, an unusual conversation, or something in between?
 - d. What kind of place or situation were you in?
5. Have you ever used the training while you were online? If you have, can you please tell me about that?
6. Do you feel you have helped anyone by using your training? If you feel you have, please tell me about that:
 - a. What did you do?
 - b. What did that person do or not do as a result of your help?

- c. Was there anything you said or did that you think was especially effective? What was it? Why do you think it was effective?
7. After your experiences with the training up 'til now, do you think you'll use it in the future? If you think so, how?

The next set of questions is about how people in your neighborhood talk about mental health, people who haven't had the MHFA training.

8. In your opinion, in what ways and how much do people in your neighborhood talk about mental health/illness?
9. When you are listening to people (who haven't had the training), what words do they use to describe mental health issues?
 - a. If they use words you've learned to avoid, do you feel the need to correct their terms? Do you correct their terms?
 - b. Are you comfortable correcting them?
10. Are there "trigger words" people use that cause you to think about or use your training?

Last, I have two questions for you about yourself:

11. If you don't mind telling me, are you over or under 40 years old?
12. Is there anything else you'd like to share with me?

That's it! Thank you again so much for sharing your time and your knowledge with me. The information sheet I gave you at the beginning has my contact information on it if there's anything else you want to tell me or any other questions or concerns you have.

Vita

Jeannette Hill Porter was born December 22, 1967 in The Bronx, New York, and is an American citizen. She graduated from Hunter College High School, New York, New York in 1985. She received her Bachelor of Arts in Economics from Swarthmore College, Swarthmore, Pennsylvania in 1989. Among other jobs, she worked for The Boys Choir of Harlem for nine years and as a reporter for the Amelia (VA) Bulletin Monitor for seven years.