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Natalie Turner

*University at Albany, State University of New York*

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Running head: RELIGIOSITY/SPIRITUALITY ON MENTAL HEALTH

Mental Health Care Treatment Seeking among African Americans and Caribbean Blacks:

What is the role of Religiosity/Spirituality?

Natalie Turner

Honors Thesis Submitted in Partial Fulfillment of a Bachelor's of Science Degree  
in Social Welfare

Research Mentor and Advisor: Julia F. Hastings, MSW, Ph.D.

School of Social Welfare

May 2017

### Abstract

According to the 2014 SAMSHA National Survey on Drug Use and Health (NSDUH), 18.1% of American adults (ages 18 and over) experienced some sort of mental health issue. Furthermore, estimations have shown that around 20% of older adults experience some sort of mental health problem. While the percentage of older adults increase, they are less likely to use mental health care services than younger and middle aged adults. In addition, racial/ethnic minorities, such as African American and Caribbean Blacks are less likely to use mental health care services. The percentage of older racial/ethnic adults is also increasing from 18% in 2004 to 22% in 2014, and this is expected to continue increasing. The underutilization of mental health services indicates that many members of the older population are left untreated, which can decrease an individual's quality of life and can result in significant costs to families, employers, and health systems. The study explores the differences in relationships between mental health care seeking behavior and strength of religious/spiritual beliefs between older adults (aged 54 years or older) and adults (18-53) from two racial/ethnic groups, African Americans and Caribbean Blacks living in the US using data from the National Survey of American Life (NSAL). Descriptive statistics and logistic regression analyses were conducted using Stata version 13.1. Preliminary analyses show that mental health treatment seeking alone is related to spirituality and/or religiosity. Significant demographic controls are age, gender, and being from the South. The study indicated statistical support for strong religious/spiritual beliefs which may promote mental health treatment seeking. Future studies will need to examine the strength of religious/spiritual beliefs on mental health care seeking behavior among different demographic groups.

Word Count: 276

**Key Words:** Aging, Mental Health Services, NSAL, Religion, Spirituality

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## **Introduction**

### *Statement of Problem*

According to the 2014 SAMSHA National Survey on Drug Use and Health (NSDUH), 18.1% of American adults (ages 18 and over) experience some sort of mental health issue (SAMSHA, 2014). More than 14.5% of the US population is 55 years or older, and this number is expected to continue increasing (Administration on Aging, 2015). Of the older population, estimations have shown that around 20% experience some sort of mental health problem (American Psychological Association, 2016; Centers for Disease Control, 2008).

Older adults are also less likely to receive mental health services than younger and middle aged persons (Neighbors et al., 2007). In one study, 65.9% of the older participants with major depressive disorder and 72.5% with anxiety were not receiving mental health care (Garrido, Kane, Kaas, Kane, 2011). The literature on older adults with mental health diagnoses have shown many reasons explaining underutilization of mental health services stemming from a lack of knowledge of the availability of sources, lack of transportation or financial means to afford the services, older adults feeling as though they can take care of the problem on their own, or that the problem will go away with time (Sorkin, Murphy, Nguyen, & Biegler, 2016). The research also indicates that older adults report being worried about the stigma associated with seeking mental health care (Garrido et al., 2011; Jiminez, Bartels, Cardenas, and Alegria, 2013). As such, while US adults and the growing number of older adults show similar levels of mental health concerns, older adults are less likely to receive care.

Racial/ethnic minorities tend to use mental health care services less than whites (McGuire and Miranda, 2008). Specifically, African Americans and Caribbean Blacks use these services at significantly lower rates compared to non-Hispanic whites (Jackson et al., 2007). In addition, the

percentage of racial/ethnic minority older adults has increased from 18% in 2004, to 22% in 2014 and is also expected to rise over the next five years (Administration on Aging, 2015). As the percentage of racial/ethnic minority elders is increasing, the type and provision of mental health services will have to adjust to become more culturally competent in order to better serve these racial/ethnic groups (Administration on Aging, 2015).

It has been found that the strength of religious beliefs increases with age (Bengston, Putney, Silverstein, and Harris, 2015). Research studies have also indicated that more frequent participation in religious/spiritual activities is associated with a lower likelihood of experiencing depression or emotional distress (Meisenhelder and Chandler, 2002; Hongtu, Cheal, McDonel, Herr, Zubritsky, & Levkoff, 2007; Taylor, Chatters, and Abelson, 2012). Yet, the research literature is not consistent. Some research report conflicting findings as to whether strength of religious beliefs and religious affiliation are associated with mental health care seeking behavior. For example, Hongtu et al. (2007) and Pickard (2006) have both shown no correlation between religious attendance and utilization of mental health services, while Pickard (2006) has shown a correlation between religiosity and the use of these services. However, neither focused upon the correlation between strength of religious/spiritual beliefs and the use of mental health services between adults and older adults among the two different racial/ethnic groups, African American and Caribbean Black. Most studies have also defined old age as those 65 years and older. However, the literature shows that life expectancies are different for persons of color. Particularly, African Americans enjoy fewer years of life than non-Hispanic Whites (USA Life Expectancy, 2016). As such, the proposed study will define old age as persons who are 54 years of age and older.

*Study Purpose*

The purpose of this study was to explore mental health care seeking behaviors among adults and older adults identifying as African American or Caribbean Black in terms of their strength of religiosity/spirituality. The research sought to gain a better understanding of the lack of mental health care service usage by older adults compared to adults among the two racial/ethnic groups, as well as whether having stronger spiritual/religious beliefs were associated with a higher likelihood of using mental health care services.

*Significance of the Problem*

As stated previously, 18.1% of adults and around 20% of older adults experience some sort of mental health problem and older adults are less likely to receive mental health services than people in other age groups (American Psychological Association, 2016; Neighbors et al., 2007; SAMSHA, 2014). Underutilizing mental health services for older adults who are in need of care may mean that significant portions of the population are left untreated. This, in turn, can decrease quality of life. The World Health Organization (WHO) defines quality of life as “individuals’ perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns” (World Health Organization, 1993). The WHO then goes on to say that quality of life is a broad concept that can be impacted by physical and mental health, social relationships, and relationships with the environment (World Health Organization, 1993). As such, a missed diagnosis of a mental health problem or the lack of treatment for such a problem can negatively impact how an older adult perceives his/herself in the context of his/her life.

Underutilizing mental health services also leads to larger scale consequences. Mental health disorders are among some of the top causes of disability in the US and can result in



significant costs to families, employers, and health systems (SAMSHA, 2016). In addition, by furthering exploration of the differences between the racial/ethnic groups in terms of religiosity/spirituality and utilization of mental health care services, a better understanding of such a difference can help to direct future culturally-based policies and practices that pertain to mental health care.

### *Theoretical Framework*

Based on the person-in-environment theory, it is key to examine an individual and an individual's actions in the context of his/her environment. The environment can directly impact the way that a person acts and in turn a person can impact his/her environment. A person's environment can be made up of religious, historical, physical, and social environments (Kondrat, 2013). For this study, strength of religiosity/spirituality is being explored to understand the impact a person's behavior may have on mental health care usage. Historical environments are also focused upon via two racial/ethnic identities -- African Americans and Caribbean Blacks. Although these two groups are often combined into one category, each holds a different historical background in the United States and may impact the strength of religiosity/spirituality. In addition, differences may be discovered in mental health care seeking behavior.

Another theoretical model of health service utilization is the Anderson Behavioral Model of Health Service Use (Anderson, 2008). This model seeks to identify factors that promote the use of health services. The most current model suggests that contextual and individual factors can impact the use of health services, much like the person-in-environment theory. Three major dynamics have been identified that can impact usage, and those are: predisposed factors, such as individual age, race, beliefs, or community structure; enabling factors, such as support (i.e. family support or community support); and need, such as perceived need of a service or mortality

rates (Anderson, 2008). The Anderson Behavioral Model does not explicitly focus on the impacts of religion/spirituality but does indicate that a person's belief system could influence his/her health care seeking behaviors.

A gap in the current literature exists on what impact an individual's sense of religiosity/spirituality can play in mental health service utilization, and if this impact is seen on different racial/ethnic and age groups. Anderson's theory suggests that physical and historical environments as well as other factors can influence people's actions and behaviors and for this study, people's health care seeking behavior. However, as of yet, there is little research that brings together the strength of religiosity/spirituality with mental health service utilization, while accounting for the differences between ages among racial/ethnic minority groups. The study examined adults and older adults from two racial/ethnic groups to assess the strength of religious/spiritual beliefs as it correlates with an increase in mental health care service usage.

### *Research Questions*

1. Since religiosity and spirituality have been positively associated with mental well-being (Meisenhelder and Chandler, 2002; Dunn and Horgas, 2000; Neighbors et al., 2007), is it possible that those who are more religious/spiritual are more likely to seek out mental health services?
2. Among African American and Caribbean Black adults 18 to 53 years and seniors ages 54 years and older what is the difference between those who have strong religious/spiritual beliefs and those with weak religious/spiritual beliefs?
3. Among African American, and Caribbean Black adults 18 to 53 years and seniors ages 54 years and older what are the difference between those who seek mental health care and those who do not?

*Definition of Major Variables*

*Age* – Adults are persons who have identified as being 18 to 53 years of age. Older adults are persons who have self-identified as 54 years of age or older.

*Race/ethnicity groups* - Persons who have self-identified as African American or Caribbean Black.

*Strength of religious/spiritual beliefs* –A scale which measures the level of importance persons hold religion/spirituality in his or her life.

*Mental health care seeking behavior* – Persons who have ever attended a counseling session for more than 30 minutes.

**Literature Review**

Taylor, Chatters, and Jackson (2007) reported that older adults were more likely to rate themselves highly on a self-rated religiosity scale compared to adults. The idea that older adults have stronger religious/spiritual beliefs is further supported by a 2004 Gallup Poll reporting that only 8% of 50 to 64 year olds and 6% of people aged 65 and older had no religious preference, compared with 16% of 18 to 29 year olds (Carroll, 2004). In addition, 65% of 50 to 65 year olds and 73% of people aged 65 and older reported that religion is very important to them (Carroll, 2004). In addition to this, there is evidence that supports the idea that increased religiosity/spirituality is not simply a cohort effect, but an aging one in general. Bengston, Putney, Silverstein, and Harris (2015) found that while the concepts of what constitutes religion or spirituality changed with cohorts, older adults were significantly more likely to consider themselves strongly religious or spiritual compared to younger adults.

In terms of mental health care seeking behavior, studies have shown that older adults are less likely to seek and receive mental health services compared to younger and middle aged

adults (American Psychological Association, 2016; Neighbors et al., 2007; Husiani, Moore, and Cain, 1994). Husiani, Moore, and Cain, in 1994, found that both white and black elderly were less likely to use formal mental health services. White and black elderly were far more likely to consult with their clergy or the family physician for mental health concerns. Pickard and Baorong (2008) have also found similar results in that older adults are more likely to speak with their clergy on matters of mental health. In this case, strength of religious/spiritual beliefs and religious attendance were important. Neighbors et al. (2007) used National Survey of American Life (NSAL) data to examine the differences between non-Hispanic Whites, African Americans, and Caribbean Blacks in terms of use of services for mental health issues (Alegria, Margarita, Jackson, Kessler, & Takeuchi, 2007). Neighbors et al. (2007) found that more non-Hispanic Whites use mental health services than African Americans and Caribbean Blacks, with older African Americans using services the least. In addition, African American women were more likely to use these services than African American men, while there was no sex difference in Caribbean Blacks.

Prior studies have also reported on the differences between religious/spiritual practices between the different racial and ethnic groups. Chatters, Taylor, Jackson, and Lincoln (2008) studied the differences of religious coping between non-Hispanic Whites, African Americans, and Caribbean Blacks. Specifically, this study used NSAL data to look at how Caribbean Blacks compared to the other two groups. Chatters et al. (2008) found that overall, most people agreed that religious coping, such as prayer, was helpful for dealing with health concerns, and that these religious behaviors were more likely to be used as coping strategies by African Americans than by non-Hispanic Whites. In addition, both African Americans and Caribbean Blacks were more likely to subscribe to the idea that prayer is important for dealing with stressful life situations.

Similarly, African Americans and Caribbean Blacks looked to God for strength and were more likely than non-Hispanic Whites to identify religious resources and behaviors as important for dealing with life situations. Overall, this study found that African Americans and Caribbean Blacks were similar in the use of religious/spiritual practices as coping mechanisms (Chatters et al., 2008). Dunn and Horgas (2000) found similar results when examining religious coping in terms of race, with people who identified as Black more likely to use prayer to cope with stress, this study, however, did not differentiate between different black ethnicities such as African American and Caribbean Black and so could not identify any possible differences between subpopulations.

Taylor, Chatters, and Jackson (2007) used the NSAL data to report on the differences in individuals' strength of religious/spiritual beliefs. The study findings show that African Americans and Caribbean Blacks were more similar to each other than non-Hispanic Whites in terms of indicating that religion was very important in their lives. Both African Americans and Caribbean Blacks had about 80% of participants report this, while the non-Hispanic Whites had significantly fewer (Taylor, Chatters, & Jackson, 2007). In addition, African Americans were more likely to rate themselves as very religious and spiritual as compared with non-Hispanic Whites and Caribbean Blacks. What this and Chatters et al.'s (2007) study have highlighted are the racial and ethnic group differences in the uses and strengths of religious/spiritual beliefs.

It has been found that women were more likely than men to report on the importance of prayer for coping, and are more likely to report turning to God for strength (Chatters et al., 2007; Dunn and Horgas, 2000; Garrido, et al., 2011). Women are also more likely to use mental health care services than men (Pattyn, Verhaeghe, and Bracke, 2015). In regard to geographic location, people in the South were more likely than those in the North to report on the importance of

prayer for coping and more likely to report turning to God for strength (Chatters et al., 2007; Taylor, Chatters, and Jackson, 2007).

Studies have compared the strength of religious/spiritual beliefs among older non-Hispanic Whites, African Americans, and Caribbean Blacks. Other studies have shown the association between religion/spirituality and mental health, and strength of religiosity/spirituality and mental health care service usage. Pickard (2006) has even identified that it is not religious association or practice that is associated with mental health care seeking behavior, but the strength of one's own religious/spiritual beliefs. Furthermore, studies have assessed that older adults are more likely to have stronger religious/spiritual beliefs compared to adults (Carroll, 2004; Taylor, Chatters, and Jackson, 2007). In addition, older adults are less likely to seek mental health care than adults (American Psychological Association, 2016; Neighbors et al., 2007; Husiani, Moore, and Cain, 1994). Where these studies have failed to focus on are any connections between the strength of religious/spiritual beliefs and an individual's likeliness to seek mental health care services among the different racial/ethnic groups, African Americans, and Caribbean Blacks and between the two age groups, older adults 54 years and over or adults ages 18 to 53.

### **Methods**

This study analyzed data from the National Survey of American Life: Coping with Stress in the 21<sup>st</sup> Century (NSAL) to assess the impact of strength of religious/spiritual beliefs on mental health care seeking behavior among two different racial/ethnic subgroups ages 18 to 53 and 54 years or older.

*Sample*

The National Survey of American Life (NSAL) data was collected by the Program for Research on Black Americans at the University of Michigan's Institute for Social Research. The NSAL was a national household probability sample consisting of 6,082 face-to-face interviews with English-speaking persons 18 years or older, including 3,570 African Americans, 1,621 Blacks of Caribbean descent, and 891 non-Hispanic Whites. The NSAL was the first major probability sample of Caribbean Blacks. Interviews were conducted throughout the United States in both rural and urban areas in order to proportionally represent African Americans in the way in which they are distributed nationally. The Caribbean Black sample was selected from these areas, and also from an area probability sample consisting of segments where Caribbean Blacks made up more than 10% of the population. The overall response rate was 72.3%. Response rates for each of the subgroups were 70.7% for African Americans, 77.7% for Caribbean Blacks, and 69.7% for non-Hispanic Whites. Participants were compensated for their time. Data collection occurred from February 2001 to June 2003.

*Measures*

*Demographics* – For the purposes of this study, respondents who reported being 54 years or older were categorized as older adults and respondents who reported being 18 to 53 years were defined as adults. Both groups were included in analyses procedures. The different racial/ethnic subgroups consisted of self-report measures. African American and Caribbean Black respondents had to self-identify as black. In addition, those identifying as black were included in the group of Caribbean Black respondents if they reported West Indian or Caribbean descent (from a predetermined list of Caribbean countries), being from a Caribbean country, or having grandparents or parents who were born in a Caribbean country. Gender and region were

also demographic variables included in analytic models. Non-Hispanic whites were not included in the analysis because this racial/ethnic group was not asked a question relating to mental health care service use. Gender was also assessed through self-reporting and respondents were either male or female. Region was assessed through self-reporting and individuals were either from the Northeast, Midwest, South or West.

*Dependent Variable* – Respondents were assessed on their mental health care seeking behavior. Respondents were asked “Did you ever in your life have a session of psychological counseling or therapy that lasted 30 minutes or longer with any type of professional?” Those who responded “yes” were considered as individuals who had used mental health care. Non-Hispanic white respondents were not asked this question during interviews, and so non-Hispanic whites were not included in this analysis.

*Independent Variables* - Respondents were asked two questions relevant to this study pertaining to strength of religious/spiritual beliefs that will be assessed in this study. They were asked “How religious would you say you are – very religious, fairly religious, not too religious, or not religious at all?” and “How spiritual would you say you are – very spiritual, fairly spiritual, not too spiritual, or not spiritual at all?” Answers of “very religious/spiritual” will be considered strongly religious/spiritual for this study.

#### *Analysis Strategy*

Frequency distributions for the dependent variable were calculated. The frequencies were weighted to the national population of African Americans and Caribbean Blacks. Frequency distributions for the independent variable, strength of religious/spiritual beliefs, were also presented. All analyses were conducted using Stata 13.1.



Second, several bivariate analyses were conducted. Chi-Square tests were calculated to assess whether the correlation between mental health service utilization and strength of religious/spiritual beliefs were significantly related. Other Chi-Square tests were used to test associations between the strength of religious/spiritual beliefs and the demographic variables. Chi-Square was also used to measure the relationship between gender and strength of religious/spiritual beliefs, race/ethnicity and strength of religious/spiritual beliefs, and region and strength of religious/spiritual beliefs. Only those with results pertaining to the final analysis were included in the results section.

For the multivariate analysis, logistic regression was used. Logistic regression was used to examine the main effect of strength of religious/spiritual beliefs on mental health care service utilization, adjusted for demographic variables.

### **Results**

Descriptive characteristics of the sample population by age are presented in Table 1 for African Americans and Caribbean Blacks. Respondents totaled 5,008 that identified as African American or Caribbean Black. There were 3,838 adults ages 18 to 53 and 1,150 adults 54 years and older. The overall average age of respondents, weighted to the national population of African Americans and Caribbean Blacks, was 42.2 years. The weighted average age of adults 18 to 53 years was 35.3 years and the weighted average of older adults 54 years and older is 65.9 years. The breakdown by gender was 44.4% of the sample identifying as male and 55.6% as female. Most of the sample lived in the South (54.7%). The remaining respondents lived in near equal percentages throughout the United States; Northeast (18.17%), Midwest (17.9%), and West (9.2%).

The sample consisted of mostly African Americans (93.9%) as opposed to Caribbean Blacks (6.1%). This was expected as the sample was weighted to the actual US population of African Americans and Caribbean Blacks. The number of African Americans under age 54 was 2,688 (72.5%), the number of African Americans 54 years and older was 882 (21.5%), the number of Caribbean Blacks under age 54 was 1,150 (4.7%), and the number of Caribbean Blacks over 54 years of age was 288 (1.4%). Strength of religious/spiritual beliefs was high, specifically among older African American and Caribbean Black adults, which supports prior research. 64.4% (n= 1,155) of older adults were considered to have strong religious/spiritual beliefs while 48.1% (n= 4,972) of adults overall (adults and older adults) were considered to have strong religious/spiritual beliefs.

In total, 660 (15.23%) African Americans and Caribbean Blacks of all ages attended a counseling session lasting longer than 30 minutes at any point in their lives. 551 of the 660 was African Americans and Caribbean Blacks younger than age 54, and 109 were 54 years of age or older. This supports prior research that has found low rates of mental health care seeking behavior among these two populations (Jackson et al., 2007; Neighbors et al., 2007).

Table 2 presents the association between region and race/ethnicity among all adults. This specific analysis compared African Americans and Caribbean Blacks (n=5,008) to non-Hispanic Whites and Hispanics (n=1,074). Bivariate analyses conducted showed a significant association between region and race/ethnicity only at the .10 level ( $p = 0.07$ ). This shows that the association between race and region that was thought to exist (with African Americans more likely to reside in the south) may not be as strong as previously thought.

Table 3 presents the association between region and strength of religious/spiritual beliefs among African Americans and Caribbean Blacks. Bivariate analyses conducted showed an

insignificant relationship between region and strength of religious/spiritual beliefs among African Americans and Caribbean Blacks ( $p = 0.85$ ).

Tables 4 and 5 present the logistic regressions for the mental health care service use variable and strength of religious/spiritual beliefs unweighted and weighted, respectively. For these two tables, demographic variables such as age, sex, and region were not held constant. The unweighted logistic regression was found to show a significant relationship ( $p < .05$ ) between mental health seeking behavior and the strength of one's religious/spiritual beliefs ( $p = 0.02$ ; 95% CI: 1.02738 to 1.429625). Thus, showing that people in the sample population with stronger religious/spiritual beliefs were more likely to seek mental health services. The weighted logistic regression was found to show a significant relationship between strength of one's religious/spiritual beliefs and mental health care seeking behavior at the .10 level ( $p = 0.08$ , 95% CI: 0.9737308 to 1.560189).

Tables 6 and 7 present the logistic regression for mental health care service use and strength of religious/spiritual beliefs controlling for age, sex, and region unweighted and weighted, respectively. The unweighted logistic regression (Table 6) was found to show a significant relationship ( $p < .05$ ) between mental health care seeking behavior and strength of religious/spiritual beliefs with the demographic variables held constant ( $p = 0.007$ , 95% CI: 1.064682 to 1.493347). This, once again, indicates that people in this sample with stronger religious/spiritual beliefs were more likely to seek mental health care services. In the unweighted logistic regression, the relationship between mental health care seeking behavior and age was also significant ( $p < .05$ ) ( $p = 0.000$ , 95% CI: 0.479307 to 0.7487005). This indicates that older adults are less likely to seek mental health care than younger adults. Table 6 also shows a

significant relationship ( $p < .05$ ) between mental health care seeking behavior and region, with the results showing that those living in the South were less likely to seek mental health care services.

Table 7, the weighted logistic regression, shows similar significant relationships ( $p < .05$ ) between mental health care seeking behavior and age ( $p = 0.001$ , 95% CI: 0.4814305 to 0.8081985), mental health care seeking behavior and sex ( $p = 0.000$ , 95% CI: 1.252004 to 1.305213), and mental health care seeking behavior and living in the South ( $p = 0.000$ , 95% CI: 0.3653102 to 0.60018). The relationship between mental health care seeking behavior and strength of religious/spiritual beliefs was significant at the .10 level ( $p = 0.062$ , 95% CI: 0.9879615 to 1.606946).

### **Discussion**

Our study originally sought to identify the role of the strength of religious/spiritual beliefs in mental health care seeking behavior among adult and older adult African American and Caribbean Blacks. Specifically, our study sought to identify any differences that exist between the two age groups among the given racial/ethnic groups. This study was guided by the inconclusive literature existing on the association between religion and mental health care seeking behavior and the researcher's interest in factors that may encourage mental health care seeking behavior among older adults, a subpopulation of the United States that continues to grow.

In terms of mental health care seeking behavior and religion/spirituality, research has found that increased participation in religious/spiritual activities is associated with a lower likelihood of experiencing a mental health concern (Herr, Zubritsky, & Levkoff, 2007; Hongtu, Cheal, McDonel, Taylor, Chatters, and Abelson, 2012; Meisenhelder and Chandler, 2002). Hongtu et al. (2007) and Pickard (2008) have both shown no correlation between religious

attendance and utilization of mental health services, while Pickard (2006) has shown a correlation between religiosity and the use of these services. However, these studies did not focus on racial/ethnic minority groups or look at any effect of age on this relationship.

In regards to the aging population, as the proportion of older adults in the US continues to rise, older adults are less likely to seek and receive mental health services compared to younger and middle aged adults (Administration on Aging, 2015; American Psychological Association, 2016; Husiani, Moore, and Cain, 1994; Neighbors et al., 2007). So, it is becoming increasingly important to identify factors that could enhance an older adult's likelihood of seeking mental health services.

Some of our results support previous literature. Our full logistic regression shows that adults (ages 18 to 53 years) were more likely to seek mental health care than older adults, and this supports Neighbors et al.'s findings (2007) ( $p = .001$ , 95% CI: 0.4814305 to 0.8081985). And, women were more likely to seek mental health care than men, supporting Pattyn, Verhaeghe, & Bracke (2015) ( $p = .000$ , 95% CI: 1.252004 to 2.017614). Both of these relationships were significant at the .05 level for the unweighted analyses. These analyses lend further evidence to the idea that older adults and males are less likely to seek mental health care.

Our results were surprising given the fact that for the unweighted full model at the .05 level, the relationship between our main independent variable, strength of religious/spiritual beliefs, and our main dependent variable, mental health care seeking behavior, was significant ( $p = 0.007$ , 95% CI: 1.064682 to 1.493347), but when this sample was weighted to the national population of African Americans and Caribbean Blacks, the relationship was only significant at the .10 level. This still indicates that African Americans and Caribbean Blacks who have

stronger religious/spiritual beliefs are more likely to seek mental health care, and supports the study conducted by Pickard (2006).

The reason for the relationship between religiosity/spirituality and mental health care service use is still unclear. One idea put forth by Pickard (2006) is that those who have stronger religious/spiritual beliefs put more faith in a higher power to lead them down their path and so experience less stigma when seeking mental health care. Stigma has already been shown to be a major barrier to mental health care seeking behavior (Garrido et al., 2011; Jiminez, Bartels, Cardenas, and Alegria, 2013) and so a decrease in the amount of stigma felt could lead to more service use. In addition, building off of this idea, those who are more religious/spiritual may be more willing to accept mental health counseling when presented with the opportunity due to increased faith in a higher power to lead them down their correct path.

One particularly interesting finding from this study concerns region and mental health care seeking behavior. In both the unweighted and weighted full regression model, African Americans and Caribbean Blacks from the south were less likely to seek mental health care. The south has usually been referred to as the “Bible Belt” due to the tendency for residents to have stronger religious/spiritual beliefs, and this has been evidenced by Chatters et al. (2007) and Taylor, Chatters, and Jackson (2007). However, our findings indicate that these stronger religious/spiritual beliefs could lead to increased mental health care service use, yet this is not the case. Instead, the findings suggest another factor superseding the impact of religious/spiritual beliefs on mental health care, such as culture or perceived stigma.

Upon further assessment of this relationship, our results show that there is also no significant relationship between strength of religious/spiritual beliefs and region among African Americans and Caribbean Blacks. This suggests that where a person lives geographically does

not impact the strength of their religious/spiritual beliefs, and this is in contrast with prior research showing the south as an area of high religiosity/spirituality. In addition, there is no significant association between region and race/ethnicity. These two factors taken together may indicate that the southern “Bible Belt” is losing its impact on African Americans and Caribbean Blacks. In other words, religion/spirituality may be becoming less important for African Americans and Caribbean Blacks in the south and this could serve as an explanation as to why the adults were found less likely to seek mental health care.

Although the study offered many strengths, the findings must be understood given a few limitations. First, we could not only address those with mental health concerns due to small sample size, instead we looked at all African American and Caribbean Black respondents as opposed to those who had mental health concerns. This could impact our results in that we found a low response rate for mental health care seeking behavior ( $n = 660$ , 15.23%) for African Americans and Caribbean Blacks overall. Limiting our sample to those with mental health concerns may have increased the percentage of those who sought mental health care. Doing so would have also allowed us to comment on the underutilization of mental health care seeking behavior. However, due to sample size this restriction was not used.

In addition, the strength of religious/spiritual beliefs was a created variable and so if this was measured directly during the interviews, our results may have been significant even at the .05 level. Also, non-Hispanic whites were not included in this study because they were not asked the question, “Did you ever in your life have a session of psychological counseling or therapy that lasted 30 minutes or longer with any type of professional?” This prevented us from analyzing African Americans and Caribbean Blacks against non-Hispanic whites.

One of the main aims of this study was to get a clearer understanding of the role of religious/spiritual beliefs on mental health care seeking behavior among older adults. However, due to the small number of older adults (n= 990) and even smaller number of older adults who have sought mental health care (n= 109), we could not perform statistical analyses that focused solely on older adults. This limited our ability to make any comments on the role of religiosity/spirituality on mental health care seeking behavior for this age group.

The study presented here served as a preliminary investigation into the relationship on religiosity/spiritual and mental health care seeking behavior. Future research will need to examine how to increase sample size among older adults completing survey research. Also, future studies may wish to distinguish between the many forms of mental health care seeking behavior to explore if there are specific types of services more likely to be used by more religious/spiritual individuals. Other directions for research include, asking additional racial/ethnic groups to participate in the sample. Suggestions for future research are important given that the proportion of older adults will rise in the next five years. Social researchers will need to respond to the changing census of the United States to address the emerging needs of the aging population as they tend to be more religious/spiritual and perhaps will use mental health care services less.



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## Tables

**Table 1:** Demographic Characteristic of the Study Sample by Age (weighted)

<b>Demographic Characteristics of the Study Sample by Age (weighted)</b>			
	<b>All Ages = 5,008 (%)</b>	<b>n Ages &lt;54 Years n = 3,838 (%)</b>	<b>Ages 54+ Years n = 1,170 (%)</b>
<b>Race/Ethnicity</b>			
<i>African American</i>	3,570 (93.91)	2,688 (72.45)	882 (21.46)
<i>Caribbean Black</i>	1,438 (6.09)	288 (1.35)	1,150 (4.73)
<b>Sex</b>			
<i>Male</i>	1,833 (44.42)	1,394 (35.06)	439 (9.36)
<i>Female</i>	3,175 (55.58)	2,444 (42.13)	731 (13.45)
<b>Region</b>			
<i>North</i>	1,407 (18.17)	1,107 (14.11)	300 (4.06)
<i>Midwest</i>	606 (17.94)	440 (13.76)	166 (4.18)
<i>South</i>	2,748 (54.69)	2,100 (42.25)	648 (12.45)
<i>West</i>	247 (9.20)	191 (7.08)	56 (2.12)
<b>Strength of Religious/ Spiritual Beliefs</b>			
<i>Strong Beliefs</i>	<b>n = 4,972* (%)</b>	<b>n = 3,817* (%)</b>	<b>n = 1,155* (%)</b>
<i>Weak Beliefs</i>	2,432 (48.12)	1,692 (33.54)	742 (14.58)
<i>Never Attended Counseling Session</i>	2,538 (51.88)	2,125 (43.82)	413 (8.06)
<b>Mental Health Care Seeking Behavior</b>			
<i>Attended Counseling Session</i>	<b>n = 4,805* (%)</b>	<b>n = 3,706* (%)</b>	<b>n = 1,099* (%)</b>
<i>Never Attended Counseling Session</i>	660 (15.23)	551 (12.63)	109 (2.6)
<i>Never Attended Counseling Session</i>	4,145 (84.77)	3,155 (65.03)	990 (19.73)

Data source: NSAL, 2001 - 2003

\*(n) is different for Strength of Religious/Spiritual Beliefs and Mental Health Care Seeking Behavior due to missing responses

**Table 2:** Bivariate Analysis of Region on Race/Ethnicity Among All Ages (n=6,082) (weighted)

<i>Bivariate Analysis of Region on Race/Ethnicity Among All Ages (n=6,082) (weighted)</i>					
	<i>Region n (%)</i>				
	<b>North</b>	<b>Midwest</b>	<b>South</b>	<b>West</b>	<b>Total</b>
<b>African American/ Caribbean Black</b>	1,407 (9.06)	606 (8.94)	2,748 (27.27)	247 (4.59)	5,008 (49.86)
<b>Non-Hispanic White/ Hispanic</b>	246 (11.5)	84 (3.96)	647 (27.21)	97 (7.47)	1,074 (50.14)
<b>Total</b>	1,653 (20.56)	690 (12.90)	3,395 (54.48)	344 (12.06)	6,082 (100)

Data source: NSAL, 2001 - 2003

Pearson's Chi Square: 176.3652; p = 0.0715

**Table 3:** Bivariate Analysis of Region on Strength of Religious/Spiritual Beliefs Among African Americans and Caribbean Blacks (n=4,972) (weighted)

<i>Bivariate Analysis of Region on Strength of Religious/Spiritual Beliefs Among African Americans and Caribbean Blacks (n=4,972) (weighted)</i>					
	<i>Region n (%)</i>				
<i>Strength of Religious Beliefs</i>	<b>North</b>	<b>Midwest</b>	<b>South</b>	<b>West</b>	<b>Total</b>
<b>Strong Beliefs</b>	663 (8.6)	296 (8.89)	1,347 (26.02)	128 (4.60)	2434 (48.12)
<b>Weak Beliefs</b>	733 (9.55)	307 (9.11)	1382 (28.68)	116 (4.54)	2,538 (51.88)
<b>Total</b>	1,396 (18.15)	603 (18)	2,729 (54.7)	244 (9.15)	4,972 (100)

Data source: NSAL, 2001 - 2003

Pearson's Chi Square: 1.9788; p= 0.85

**Table 4:** Logistic Regression of Mental Health Care Seeking Behavior and Strength of Religious/Spiritual Beliefs Among African Americans and Caribbean Blacks (n=4,773) (unweighted)

<i>Logistic Regression of Mental Health Care Seeking Behavior and Strength of Religious/Spiritual Beliefs Among African Americans and Caribbean Blacks (n=4,773) (unweighted)</i>						
Mental Health Care Seeking Behavior	Odds Ratio	Standard Error	Z	p-value	95% Confidence Interval	
Strength of Religious/Spiritual Beliefs	1.212257	0.1020099	2.29	0.022*	1.02738	1.429625

Data source: NSAL, 2001 - 2003

\*p<.05; \*\*p<.10;

**Table 5:** Logistic Regression of Mental Health Care Seeking Behavior and Strength of Religious/Spiritual Beliefs Among African Americans and Caribbean Blacks (n=4,773) (weighted)

<i>Logistic Regression of Mental Health Care Seeking Behavior and Strength of Religious/Spiritual Beliefs Among African Americans and Caribbean Blacks (n=4,773) (weighted)</i>						
Mental Health Care Seeking Behavior	Odds Ratio	Linearized Standard Error	t	p-value	95% Confidence Interval	
Strength of Religious/Spiritual Beliefs	1.23256	0.1449121	1.78	0.081**	0.9737308	1.560189

Data source: NSAL, 2001 - 2003

\*p<.05; \*\*p<.10;

**Table 6:** Logistic Regression of Mental Health Care Seeking Behavior and Strength of Religious/Spiritual Beliefs Among African Americans and Caribbean Blacks, Controlling for Age, Sex, and Region (n=4,773) (unweighted)

<i>Logistic Regression of Mental Health Care Seeking Behavior and Strength of Religious/Spiritual Beliefs Among African Americans and Caribbean Blacks, Controlling for Age, Sex, and Region (n= 4,773) (unweighted)</i>						
Mental Health Care Seeking Behavior	Odds Ratio	Standard Error	Z	p-value	95% Confidence Interval	
<b>Strength of Religious/Spiritual Beliefs</b>	1.260928	0.1088355	2.69	0.007*	1.064682	1.493347
<b>Age</b>	0.599047	0.0681578	-4.5	0*	0.479307	0.7487005
<b>Sex</b>	1.469486	0.1366736	4.14	0*	1.224608	1.76333
<b>Region<sup>†</sup></b>						
<b>Midwest</b>	1.407487	0.1839265	2.62	0.009*	1.089461	1.818348
<b>South</b>	0.640327	0.631651	-4.52	0*	0.5277582	0.7769063
<b>West</b>	1.674099	0.2868382	3.01	0*	0.0672987	0.1353828

Data source: NSAL, 2001 - 2003

\*p<.05; \*\*p<.10;

<sup>†</sup>North = Reference Group

**Table 7:** Logistic Regression of Mental Health Care Seeking Behavior and Strength of Religious/Spiritual Beliefs Among African Americans and Caribbean Blacks, Controlling for Age, Sex, and Region (n=4,773) (weighted)

<i>Logistic Regression of Mental Health Care Seeking Behavior and Strength of Religious/Spiritual Beliefs Among African Americans and Caribbean Blacks, Controlling for Age, Sex, and Region (n= 4,773) (weighted)</i>						
Mental Health Care Seeking Behavior	Odds Ratio	Standard Error	t	p-value	95% Confidence Interval	
<b>Strength of Religious/Spiritual Beliefs</b>	1.26	0.1528579	1.91	0.062**	0.9879615	1.606946
<b>Age</b>	0.6237719	0.080589	-3.65	0.001*	0.4814305	0.8081985
<b>Sex</b>	1.589359	0.1891371	3.89	0*	1.252004	2.017614
<b>Region<sup>†</sup></b>						
<b>Midwest</b>	0.8882227	0.1705219	-0.62	0.54	0.604453	1.305213
<b>South</b>	0.4682434	0.0579773	-6.13	0*	0.3653102	0.60018
<b>West</b>	1.057993	0.1889026	0.32	0.753	0.7396383	1.513373

Data source: NSAL, 2001 - 2003

\*p<.05; \*\*p<.10;

<sup>†</sup>North = Reference Group