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The Stigma of Depression: Black American Experiences

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ABSTRACT

While stigma is a large barrier for all racial/ethnic groups, research suggests that stigma has a particularly strong impact on the help-seeking behaviors and service use patterns of Black Americans. In this qualitative study, in-depth, semi-structured interviews were conducted with 17 Black American men and women, ages 21 to 57, who have experienced depression. Several thematic categories emerged: (a) race/culture-specific aspects of dealing with depression; (b) the impact of the diagnosis on depression sufferers; and (c) pushing back against the stigma. These findings highlight the impact of sociocultural factors like stigma on illness experiences, help-seeking behaviors, and service use patterns among Black Americans. They also offer targets for intervention to increase service rates and improve care for Black Americans with depression.

KEYWORDS

Black Americans; depression; illness experiences; mental health and illness; stigma

Introduction

Individuals with identities not considered "normal" in society often experience stigma. Stigma can be defined simply as "an attribute that is deeply discrediting" (Goffman, 1963, p. 3). It is a characteristic, behavior, or identity seen as "incongruous with our stereotype of what a given type of individual should be" (Goffman, 1963, p. 3). Stigmatizing behavior from others can take many forms, including social distancing and discrimination. Individuals might also experience a reduction or loss of social status (Link & Phelan, 2001).

Stigma is a problem common to many who have suffered from mental illness. In many ways, it can exacerbate their distress (Yang et al., 2007). Even though this experience of stigma is universal, the impact and implications can be different, and arguably worse, for racial/ethnic minorities (Bailey, Blackmon, & Stevens, 2009; Mishra, Lucksted, Gioia, Barnet, & Baquet, 2009; United States Department of Health and Human Services [USDHHS], 2001). Historically, people of color have been stigmatized and marginalized because of their racial and/or ethnic identity. Adding another stigmatizing identity in the form of a mental illness can have serious repercussions for people of color (Bolden &Wicks, 2005; Conner, Copeland, et al., 2010; Gary, 2005; Matthews, Corrigan, Smith, & Aranda, 2006).

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Although depression and stigma have been investigated a great deal, research focusing on the stigma experienced by Black depression sufferers is sparse by comparison. In this study, we address this gap in the literature through interviews with 17 Black American men and women about their experiences with depression and the stigma they have experienced. Through these interviews, we can understand more about how stigma is understood, experienced, and combated in Black communities as well as how stigma can operate as a barrier for those seeking help for depression.

Stigma in Black communities

Perhaps one of the largest social barriers studied in mental health service use research is stigma. Actual experiences or the fear of being stigmatized keep a large number of people who might benefit from treatment out of services (Anglin, Link, & Phelan, 2006; Corrigan, 2004; USDHHS, 1999). Although stigma is a large barrier for all racial/ethnic groups, research has found that stigma is more of a factor in the illness and treatment experience of Black Americans than it is for many other racial/ethnic groups (Anglin et al., 2006; Bailey et al., 2009; Cruz, Pincus, Harman, Reynolds III, & Post, 2008; Rusch, Kanter, Manos, & Weeks, 2008). Some Black Americans have discussed the existence of social proscriptions to keep matters private and not to discuss their struggles with others (Carpenter-Song et al., 2010; Conner, Copeland, et al., 2010). Others believe that they will be treated negatively, discriminated against, or socially excluded if others find out about their mental health problems (Carpenter-Song et al., 2010; Mishra et al., 2009). Regardless of the type experienced or feared, stigma stops a large number of Black Americans from seeking treatment.

Many Black Americans believe that the stigma attached to mental illness is felt more strongly in Black communities (Bailey et al., 2009; Conner, Copeland, et al., 2010; Moran, 2004). Individuals whose mental illness is known by others have reported experiencing stigmatizing attitudes and behaviors from people in their communities (Conner, Lee, et al., 2010). Similarly, individuals whose mental illness is not known by others have expressed reluctance to reveal that they have mental disorders for fear that they will be subjected to ridicule and rejection (Carpenter-Song et al., 2010; Mishra et al., 2009). A desire to avoid being labeled as "crazy" or subjected to social exclusion can cause some to hide their illness and/or the fact that they seek treatment (Black, Gitlin, & Burke, 2011; Conner, Lee, et al., 2010; Matthews et al., 2006; Mishra et al., 2009). For others, it might cause them to delay seeking services or avoid treatment altogether (Alvidrez, Snowden, & Kaiser, 2008; Black et al., 2011; Calloway, 2006; Mishra et al., 2009).

Some believe that stigma is stronger in Black communities because individuals simply lack information about mental disorders and treatment

(Conner, Copeland, et al., 2010). However, even after interventions to educate Black Americans about mental illness and reduce stigma, stigmatizing views can continue to be held and in some cases strengthened (Rao, Feinglass, & Corrigan, 2007). The precarious social status of Black Americans in the United States might contribute to stronger stigmatizing attitudes and behaviors in Black communities. Problems with mental illness are viewed as "reduc[ing] one's social standing and life opportunities" (Matthews et al., 2006, p. 262). For groups like Black Americans who occupy statuses that have historically pushed them to the margins of many social spaces, adopting another potentially stigmatizing identity is not something done easily because it can come with serious threats to one's status or reputation (Black et al., 2011; Bolden & Wicks, 2005; Conner, Copeland, et al., 2010; Gary, 2005; Matthews et al., 2006). Some research has found that African-Americans more than Latinos or Whites desire larger physical and social distance from those with mental illness (Rao et al., 2007). It might be that Black Americans who do not suffer from mental illness fear losing their tenuous status because they are associated with someone who is ill (Abdullah & Brown, 2011; Rao et al., 2007).

The fear of being found guilty by association can also produce stigmatizing attitudes and behaviors from family members of those diagnosed with mental illness. Many Black Americans suffering from mental illness have expressed fears of experiencing stigmatizing attitudes or social exclusion from family and friends when experiencing a mental health problem (Alvidrez et al., 2008; Cruz et al., 2008).

However, this is not the experience of all. For some Black Americans, having a serious mental illness does not bring familial exclusion. In their study of ethno-cultural variations in the experience and meaning of mental illness, Carpenter-Song and colleagues (2010) found that Blacks were the least likely of the racial/ethnic groups studied to believe that their family would be disappointed in them because of their illness.

Specific study aims

Most of the research on stigma and mental illness focuses on mental illness in general or on mental illnesses other than depression. A small subset of that research examines the experiences of Black Americans, and only a few of those have examined depression and stigma. We sought to add to this body of research and designed a study that would investigate, among other topics, the stigma attached to depression and mental health service use among Black Americans. Through qualitative interviews, we explored Black Americans' experiences with depression, including experiences of stigma in Black communities. Although we highlight the experiences of stigma among Black sufferers of depression, we do not argue that stigma itself is unique to

Black Americans who are depressed. Rather, we seek to explore how the stigma Blacks encounter and experience is unique. It is important to recognize and understand these differences when designing and implementing interventions targeting Black Americans.

Method

Gathering information on this topic can be accomplished through a number of means. For this study, the first author and primary researcher utilized the qualitative interviewing approach. Intensive interviews allowed her to (a) move beyond the surface of experiences and extract more details; (b) explore various statements and/or topics; and (c) ask about feelings, thoughts, perceptions, and behaviors (Charmaz, 2006). This approach was also useful because of the population being studied. Research has shown that when collecting data from African-American research participants, this group prefers in-person, face-to-face interviews as opposed to telephone or mail surveys (Burlew, 2003). Conducting interviews also gives the researcher an opportunity to explore the richness of the ethnic/racial minority experience and illuminate some of its nuances that, as a method, quantitative analysis is not designed to capture. Particularly in health research, the qualitative approach provides more detailed information about the complex experience of health and nature of health behaviors (Stewart, Makwarimba, Barnfather, Letourneau, & Neufeld, 2008).

Sample/study participants

For this study, the first author wanted to speak with individuals 18 years of age or older who identified as Black or African-American and responded "yes" to at least one of the following: (a) has felt sad, empty, or depressed for two weeks or more during their life; (b) has been told by a doctor, pastor, coworker, family member, or friend that they were depressed; or (c) has seen a doctor, counsellor, or mental health professional for depression. A total of 17 Black American men and women from a Midwestern community were recruited using flyers posted at a variety of locations including local colleges and universities, libraries, area churches, social service agencies, doctors' offices, and outpatient mental health organizations. As shown in Table 1, the majority of the 17 participants were women ($N = 13$). Participants' ages ranged from 21 years of age to 57, with the majority of participants falling in the 22–29 and 40–49 age ranges. Nine participants were diagnosed with major depression by a mental health professional, three were diagnosed by a medical physician, and five were self-diagnosed. Collectively, the study participants had achieved a high level of education, with five completing or pursuing post-bachelor's education. Two participants were college graduates, six reported completing some college, three

Table 1. Participant characteristics.

Name	Age (in years)	Gender	Employment Status	Level of Education	Method of Diagnosis
Carol	24	Female	Employed	Completed high school; current[a] undergraduate student	Self-diagnosed
Denise	26	Female	Student	Earned a bachelor's degree; current[a] graduate student	Clinically diagnosed (by a friend who was a mental health professional
Derrick	40s	Male	Employed	Earned a bachelor's degree	Clinically diagnosed by a mental health professional
Devon	32	Female	Employed	Some college	Self-diagnosed
Donna	37	Female	Unemployed	Earned a bachelor's degree; career-specific training	Self-diagnosed
Doris	57	Female	Unemployed; collects Supplemental Security Income (SSI)	Completed the 11th grade	Clinically diagnosed by a physician
Drucilla	49	Female	Employed	Completed high school	Clinically diagnosed by a physician
Elisa	28	Female	Student	Earned a master's degree; current[a] graduate student	Clinically diagnosed by a mental health professional
Janelle	27	Female	Employed	Earned a master's degree	Self-diagnosed
Kamille	26	Female	Student	Earned a master's degree; current[a] graduate student	Clinically diagnosed by a mental health professional
Keith	55	Male	Unemployed	Earned a bachelor's degree	Clinically diagnosed by a physician
Laura	21	Female	Student	Completed high school; current[a] undergraduate student	Clinically diagnosed by a mental health professional
Margie	49	Female	Employed	Earned a professional graduate degree; current[a] graduate student	Clinically diagnosed by a mental health professional
Miller	43	Male	Employed	GED	Clinically diagnosed by a mental health professional
Richard	39	Male	Unemployed	Some college	Clinically diagnosed by a mental health professional
Shalesa	35	Female	Student	Earned a master's degree; current[a] graduate student	Clinically diagnosed by a mental health professional
Sidney	28	Female	Employed	Completed high school; current[a] undergraduate student	Self-diagnosed

[a]Status at the time of study participation.

finished high school or received a GED, and one participant, the eldest in the study, did not graduate high school, finishing the eleventh grade.

Interview procedures

Participants were recruited during the summers of 2007 and 2008. No compensation was offered during the summer 2007 recruitment period,

which included eight college-educated and/or professional women. During the second recruitment period, five women and four men were recruited and completed interviews. These participants were given a $10 gift card to a grocery or discount store for their participation. The first author conducted these semi-structured, open-ended interviews in locations of the respondents' choosing and included respondents' homes and local coffee shops. The interviews were conducted using an interview guide designed to have participants reflect on their experience(s) with depression, the cultural messages they received regarding depression, and how those messages shaped their thoughts about depression and help-seeking. Interviews were audio-recorded with the participants' permission and ranged from 30 minutes to 2.5 hours. All participants' names were changed to maintain confidentiality.

Analysis

The interviews were transcribed verbatim by the first author, trained research assistant, or professional transcriptionist. Many of the "ums," "likes," and "you knows" were removed when appropriate to improve the clarity of the message. Even though the interviews yielded a wealth of information about Black Americans' experience with depression, the first author wanted to focus on the topic of stigma.

The first author performed a thematic analysis on the participants' transcripts to detect relevant themes. This approach, as outlined by Braun and Clarke (2006), was selected because it views analysis as a process that allows the researcher to identify, refine, and report themes within the data, similar to the grounded theory approach developed by Glaser and Strauss (1967). However, grounded theory insists that the analysis contribute heavily to theory development which may not be the desired goal or outcome of some qualitative research. A simpler "*thematic* analysis means researchers need not subscribe to the implicit theoretical commitments of grounded theory if they do not wish to produce a fully worked-up grounded-theory analysis" (Braun & Clarke, 2006, p. 8). For a topic as understudied as Black American mental health, the freedom to simply explore the richness of the data without pointedly contributing to the theory construction or reframing is welcomed and refreshing.

While describing thematic analysis as "simple," we do not mean to imply that this method is easy or plain. According to Braun and Clarke (2006), a number of factors must be considered: (a) Will the analysis be a "rich description of the data set or a detailed account of one particular aspect" (p. 11); (b) Will one be using an inductive or deductive approach to the analysis? (c) Is the level of analysis explicit or interpretive? (d) Is the researcher using an essentialist or a constructionist epistemology? Even though a number of topics were discussed during these qualitative interviews,

the thematic analysis focused on one particular aspect of the data: stigma—how it was encountered, experienced, and understood by participants. The first author approached the data inductively, allowing the themes to come from the data itself, not fitting the data into pre-set categories. The level of analysis was more interpretive in that the goal was to "to identify or examine the *underlying* ideas, assumptions, and conceptualizations—and ideologies—that are theorized as shaping or informing the semantic content of the data" (Braun & Clarke, 2006, p. 13). In other words, in examining the experiences of stigma, the first author wanted to better understand what informed how participants interpreted, made sense of, and responded to these experiences. The first author also made sure to bring a constructivist orientation to this work, an epistemology that "does not seek to focus on motivation or individual psychologies, but instead seeks to theorize the socio-cultural contexts, and structural conditions, that enable the individual accounts that are provided" (Braun & Clarke, 2006, p. 14).

The first author moved through the analysis in the six phases of analysis as outlined by Braun and Clarke (2006):

(1) Familiarize yourself with the data and formulate some ideas and thoughts about the data.
(2) Generate initial codes.
(3) Sort through the codes, searching for and then constructing themes.
(4) Review the themes, selecting those that best reflect the data.
(5) "Define and refine" themes, "identifying the 'essence' of what each theme is about (as well as the themes overall), and determining what aspect of the data each theme captures" (p. 22).
(6) Write the results section.

After becoming familiar with the data and focusing keenly on the participants' experiences, particularly around stigma, the first author began the process by developing inductive codes, described by Boyatzis (1998) as codes that arise based on how the researcher reads and interprets the data. These codes were then sorted and grouped by using loose themes that contextualized the coded data. The first author then constructed solid themes around those codes. The themes were intentionally kept broad to ensure that the themes remained reflective of the data and not too interpretative. The first author then reviewed these themes and then collapsed them once again, creating even broader thematic categories. In order to increase the rigor and interpretive value of the research, the first author sought out another researcher, the second author, to independently review the transcripts, codes, and themes. The first and second author then met to discuss the final themes. While the second author agreed with how the themes were developed, he recommended not collapsing the themes into just three

Table 2. Major themes and subthemes.

Major Themes	Subthemes
Race/Culture-Specific Aspects of Depression Experience	Racializing and Gendering of Depression
	Stigma Felt More Strongly in Black Communities
	Experience and Disclosure of Depression as Taboo
Impact of Stigma	Diminished Help-Seeking
	"Outted and Ousted"
	Shame and Internalized Stigma
Pushing Back Against the Stigma	Seeking Treatment
	Disclosing to Other Black Americans
	Study Participation

categories, stating that it potentially undermined the richness of the participants' experiences. The first author agreed but felt that having too many themes did not capture the elements that were shared among experiences. The authors then decided to include both the three broad, overarching themes as well as the "richer" themes, listing them as subthemes (see Table 2).

Results

Participants spoke strongly about the experience and impact of stigma during the active phases of their depression. Their responses were divided into three main categories: race/culture-specific aspects of dealing with depression, the impact of the diagnosis on those suffering from depression, and pushing back against the stigma. Subthemes of these broader themes are also included and identified as "aspects," "consequences," or "methods."

Race/culture-specific aspects of depression experience

It is no surprise that many Black individuals experiencing depression fear being seen as "crazy" and/or "weak." What is perhaps most surprising is that for many Black Americans there is a racializing and gendering of "crazy" and weakness, a notable aspect of how the depression experience is interpreted and understood. For some respondents, being "crazy" was not only an indictment on one's mental status but also of one's racial status. Janelle stated that many Blacks characterized other Blacks with depression as being "crazy like those White people." Respondents believed that weakness was a characterization entangled with race and sometimes gender. Shalesa believes that there is an "image of the strong Black woman or the strong Black man" that many Black Americans feel they must emulate. Janelle feels that it is this image that forces some people to "deny" or "not acknowledge" the fact they are depressed, "especially Black women." She went on to say that it is "'cause it's always 'oh, you're the matriarch, you have to be the strong one' and you know, it's kinda like you're not allowed to be depressed

almost." Kamille felt that her "image of what depression is" was shaped by the cultural messages she received about depression. She said that it was not until later that she came to understand that depression affected many and the image was not simply "White women who can't deal with life." Keith had this to say when describing his depression:

> I don't know if you asked, another manifestation of the depression is tears. I'd be just driving, you know, and then all of a sudden I'm crying. I don't know if it's a song on the radio, but the tears, you know? I'm just, I'm thinking about this or that, and for an African-American male to do that in public, you feel very vulnerable, you know? It's a sign of weakness. You know, it's like an Achilles heel. And especially if you came up in the streets, that's something you never want to do because, you know, it's like that little triple wildebeest: you don't stand a chance. [laughs]

Although the stigma attached to mental illness is not unique to Black Americans, many respondents felt that their experiences were indeed different from those of other races, suggesting that stigma may be stronger in Black communities. Richard observed that "not only in the general populace is there a stigma, but it's there in our community on a very strong level." Other respondents also shared this belief, indicating another strong aspect of the depression experience of Black Americans. Denise stated that depression and treatment were "even more stigmatized in the Black community than in any other community." Kamille's response suggested that individuals with predominately Black social networks may be less willing to discuss being depressed than those with predominantly White or mixed-race networks:

> Like, the core of people that I socially interact with are Black. I think that would've made me less likely to come and be like, 'hey, guess what? I'm depressed.' So, I think that made me even more hesitant to broach the subject or to really talk about the real deal about how I was feeling.

Similarly, other respondents believed that people in White communities were more accepting of depression. Laura stated that she believed "for Caucasians, in general, [depression] is more accepted." Elisa agreed, stating,

> [Whites] would be understanding and sympathetic towards it, and they would listen to me and not tell me, 'oh you should just do this' or 'you should get over it' and things like that 'cause I feel like that's how a lot of my family members reacted to my mom when she talked about her depression.

Respondents also described a cultural environment in which symptoms of depression, including increased suicidal ideation, were not only stigmatized. There also were strong taboos concerning discussion of the topic. Therefore, the taboo nature of disclosure is another important aspect of Black Americans' depression experiences. Laura stated that depression "isn't really a widely talked about issue in the African-American community" and that "it

was pretty taboo within the African-American community itself." Janelle also talked about depression as being "a taboo subject in the Black community." Miller also used the term "taboo" to describe why be believes Black Americans found it difficult to talk about or seek help for their depressed feelings. Kamille stated that the taboo around mental health problems extends beyond depression to suicide: "I think it's extremely taboo to talk about suicide, or like there's a perception that Black people don't commit suicide, like it's not even an option, you know?"

The impact of stigma

Many of the respondents stated that the impact of stigma can have real consequences concerning whether an individual seeks help for depression. Richard believed stigma diminished help-seeking for Blacks with depression, stating, "I mean, they don't even want to go to a doctor. [laughter] The stigma again. [Others will] think you are weak or, you know, different." He went on to say that even when an individual does seek help, "all they're gonna do is give me some medication and people are going to tease me." In addition, Sidney said that Blacks might be less willing to discuss their mental health problems because they "don't want people talking about them" or they "don't want people to treat you differently, like you have a problem."

These fears of being stigmatized led some respondents to hide their depression. Carol felt that the stigmatization of depression and its symptoms may make many individuals reluctant to "tell anyone 'cause people might think [they're] crazy." Also, depressed Black Americans may have more to lose if/when their depression diagnoses were revealed. Kamille addressed the consequence of being what the first author would like to term as "outted and ousted," stating the following:

> I think that my perception of or my experience of being a Black woman in a department full of White people, one of my fears was that I wouldn't be taken seriously as a student if it was widely known that I was depressed. Or there would be a perception that I can't perform to the best of my ability or get things done. And I think my experience as a Black woman colors that perception of the situation for me. I think I didn't want it to be another strike, so to speak, on my record. And I feel like they might be able, or certain people might be willing to give Suzie [laughs] White grad student more leeway than they would me automatically, so for me coming in talkin' about I'm depressed, and I need special concessions, I think I just thought that I wasn't likely to get that. In fact, I thought that people might just look at me as I'm just incompetent and don't belong here.

Kamille's thoughts highlight an issue that is shared between Blacks and Whites, although for different reasons: that Blacks are not expected to be depressed. From national studies that applaud Black Americans' ability to "sustain a high degree of mental health" (USDHHS, 2001, p. 54) to

laypersons who believe that Black Americans have endured so much historically (Thompson, Bazile, & Akbar, 2004), there is almost an expectation that Black Americans can deal with anything. For Kamille, as a Black woman, a failure to keep up appearances or "to appear a certain way one hundred percent of the time" had very real consequences in the wider, Whiter world: "… people aren't gonna take me seriously. Or they're gonna try to prevent me from, you know, finishing this degree or whatever." For others, it meant strong assumptions about one's identity. Laura stated the following:

> I think with Caucasians, it's easier for them to admit that they're depressed, but for African-Americans, there's more of a sense of a struggle within the community, and to be depressed for what seems like no reason seems almost shameful.

This idea that depression can be shameful has serious implications for those who are depressed. Taboos concerning the symptoms of depression as well as the shame associated with seeking treatment can create another consequence of stigma—internalized stigma. For example, when Margie was asked about how she felt about the statement that individuals with depression were weak, she stated,

> I still think, unfortunately, there are sort of stereotypes and myths that are well-ingrained in our society and therefore well-ingrained, some more than others though, especially the one about depressive people are weak. I mean, just like we have internalized racism, I think I have internalized feelings about myself based on having emotional problems. And I think they're very hard to overcome, if you could ever overcome them. I mean, you're kind of like always recovering. Sort of like a recovering alcoholic, you're kind of recovering stigma, you know?

This internalized view can damage both the individual and others around them. Shalesa believed that her father-in-law's negative views about individuals with depression came from his own "shame" around taking antidepressants.

Pushing back against the stigma

Many of the respondents reported that even though they felt individuals with depression are stigmatized, they found ways to push back against the stigma. One method many participants discussed was simply seeking treatment. Richard said that he "learned you've got to look over the stigma, look over the whatever, because you're doing something to help yourself." Denise said,

> I kinda felt weird about having formal sessions with a psychotherapist initially because I feel like depression is really stigmatized and I feel like if people know that you're going to a psychologist, they think that you're crazy, so I think now I feel better about that kinda thing.

Others believed stigma must be confronted by disclosing their depression to other Blacks. Thus, sharing one's experience became another method of combating stigma. Janelle said that "once you talk about it, get it out on the table, and people start to understand it, I think it'll be less of a taboo." Kamille talked about how she eventually told her family and close friends about her depression. She said,

> It almost seemed like it was becoming like a big secret, and I didn't want it to be like that. I didn't want to have something else on my plate where I accidentally mentioned going to therapy or, like, taking medication, and people are like 'what?' You know? Like, 'when did that happen?' So, I didn't want it to be like a secret because I didn't feel like I had anything to hide from them.

Coming to terms with her depression helped her realize and acknowledge "I'm still Black. I'm still the same person I was before. It doesn't make me weak." Some respondents recognized that their personal attempts to push back against the stigma could also push against the stigma that existed in Black communities at large. Elisa described her process:

> I think the fact that… after a while I insisted on talking about it as if it was something real and not like some whiny BS like my mother might've said, like 'White people talk about stuff like that.'

Derrick addressed the image of strength and said that treatment could support or aid those cultural images: "If depression is a feeling that's going to make you ill, then treatment is going to come in and show you how to avoid it, or correct it, or make you feel stronger." Drucilla challenged the image of people with depression as "crazy" people who see a "shrink," saying that therapy is simply "talking to somebody 'cause you're depressed."

A few respondents expressed that this study and their participation in it was also a method of challenging the stigma around mental illness. Carol said, "It's really a great thing that you're doing, and it's very needed." Shalesa "really appreciate[d] this opportunity to talk about depression because it doesn't come along often enough at all." She went on to say that she was "really excited" when she saw the flyer for the study "because [she] wish[ed] that [she] had access to something years ago when [she] was really struggling, and [she] hope[d] that whatever becomes of this research that it, it helps someone else." However, one respondent suggested that instead of focusing on differences in experiences, we should instead focus on the universality of the disorder:

> I don't know why do society in general have to divide, redline, different cultures, you know? It just seems like to me that everybody gets depressed every now and then or whatever. Why would another culture be depressed more than or be more susceptible to depression than another? I don't understand why society deal with people like that.

Discussion

Stigma is a major barrier keeping many people with mental health problems out of services. For Black Americans, the impact of stigma can be more detrimental in that it is not the only marginalizing marker they must endure (Bolden & Wicks, 2005; Conner, Copeland, et al., 2010; Gary, 2005; Matthews et al., 2006). Through this study, we sought to learn more about Black Americans' depression experience. We found that stigma was a major part of that experience and discovered the various ways stigma is both experienced and combated.

The results of this study highlighted the stigmatizing messages Black Americans can receive about depression, help-seeking, and treatment. Respondents discussed their belief that Black Americans in general see people with depression as "crazy" and/or "weak." As shown in previous research (Alvidrez et al., 2008; Calloway, 2006; Mishra et al., 2009), these beliefs made it difficult for those experiencing depressive symptoms to seek help for their problems. Respondents' reports of hiding their symptoms or the fact that they sought treatment to avoid being labeled or treated differently echoed findings of other studies (Conner, Lee, et al., 2010; Matthews et al., 2006; Mishra et al., 2009). Some respondents attributed the stigmatization of those with depression to a lack of education about the disorder. However, other respondents believed that individuals themselves can hold these beliefs, internalize them, and thus, believe their social statuses and/or standings in their community are at risk or being challenged. It was these fears that respondents stated forced some to hide their depression and others to turn to those outside of their Black social networks and communities to seek support.

One of the more novel ideas to emerge from this study was the fact that the negative characteristics of those with depression were often racialized and/or gendered. A number of respondents talked about how being "crazy," "weak," or depressed itself were traits of other races, namely Whites and particularly White women. The idea that depression was something that did not, or should not, affect Blacks was clearly implied if not stated outright. While previous research by Borum (2012) identified this racializing and gendering of depression as protective for Black women, these participants found that these views of depression and subsequent help-seeking complicated their depression and help-seeking experiences. By using racialized and gendered language to describe depression and the depressed, some were forced not only to contemplate the existence of a mental illness, but also their identity as Black American men and women. For them, it was not enough to be weak or crazy because of their illness, but also less of a "Black" man or woman. These characterizations of and responses to depression made many respondents believe that depression and treatment were more stigmatized in Black communities. They also shared that talk of depression and

treatment was taboo in Black communities, creating feelings of shame in some. The oppressive environment created for many respondents forced some to turn to individuals outside of their family, friends, and community to seek understanding and consolation.

Although the belief that depression was more stigmatized in Black communities is similar to findings in previous research (Bailey et al., 2009; Conner, Copeland, et al., 2010; Moran, 2004), several findings presented here go beyond the current literature. For example, our interviews suggest that Blacks may resort to turning to those outside of their families and racial/ethnic communities for support while hiding their depression within the community to maintain social ties. This suggests that Black Americans with depression might believe they must navigate multiple identities in various spaces, which can in turn add to their (di)stress. Respondents also discussed the importance of fighting the stigma experienced and seeking help when needed. Some talked about how they combated stigma at the individual or personal level, but they also expressed the need for community-level intervention to educate people about depression and the importance of treatment. Many said that studies like this aided that goal.

Limitations and future directions

Even though this study offers a substantial contribution to the study of the stigmatization of depression in Black communities, it is not without its limitations. One major limitation of this study is that respondents were allowed to self-identify as depressed. Although we tried to use participation criteria that reflected diagnostic criteria, we might have captured individuals who would not be viewed as "depressed" in a clinical setting. Another limitation is that beliefs about Black communities were entirely based on the perceptions of the respondents. Even though it is important to know about how individuals with depression believe they are being viewed and treated, the work did not interview members of the wider Black American community, including those who did not identify as having depression.

The limitations of this study not only illuminate areas of concern but also highlight directions to take future work in this area. As previously mentioned, future directions in research may extend beyond talking to depression sufferers themselves and include the broader community's beliefs about depression and help-seeking. Although it is important to understand the perceptions Black Americans diagnosed with depression have about depression and treatment, it is equally important to assess the actual community climate about depression and treatment by talking to those in the community who have not experienced depression. These climate-assessment studies can also be replicated to examine the "temperature" within families and in mental health care settings. Future studies

should also look more closely at the practice of going outside of Black social networks and accessing spaces that are non-Black for depression support as well as how Blacks with depression negotiate their positions in both spaces.

Conclusion

Even though the stigma of mental illness is a barrier for many seeking services for mental health treatment, it is a particularly strong impediment for Black Americans. It is important that research continue to better understand Blacks' experiences with depression and stigma both inside and outside of Black communities. By understanding their perceptions of their community and its beliefs about them we can look toward designing and implementing interventions that reduce stigma and increase understanding and support within Black communities for those that struggle with depression and other mental health problems.

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