SO DAYI: PAN AFRICAN STUDIES STUDENT JOURNAL Volume 4 2023

SO DAYI: PAN AFRICAN STUDIES STUDENT JOURNAL

Spirituality, Gender, and Health

Volume 4 July 2023

California State University, Los Angeles

Pan African Studies Department

Student Publications

So Dayi: Pan African Studies Student Journal

Volume 4, August 2023

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Editorial

By Serie McDougal, III Ph.D.

This volume includes a set of papers written by students from Pan African Studies 4000 African American Psychology course. Each of the authors used their knowledge and their imaginations to envision different ways to better understand and improve the spiritual and mental health conditions of people of African ancestry. Two of the students who have papers in this volume presented their papers at the 47th Annual National Council of Black Studies (NCBS) Conference in Gainesville, Florida. Ms. Rachael Adeniran explores the relationship between culture, spirituality and menta health among people of African descent. Ms. Kimmie Gilbert examines culturally relevant interventions for African Americans with eating disorders. Mr. Amere Wofford discusses the prospects of introducing project-based Afrocentric psychology courses at the high school level on the interest of Black students in the field of mental health. Finally, Ms. Ashley Pedraza discusses the impact of gendered racism on Black women's utilization of mental health services.

One of the aims of our journal is to produce scholarship that provides the understanding necessary to enhance the lives of people of African descent. Another aim is to produce solution oriented scholarship, where our students present pathways forward, pose new questions, and propose potential remedies to current and ongoing challenges. The papers in this volume contribute to this tradition in creative new ways.

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Introduction

By Precious Zama Dlamini, M.P.H.

The 2023 Fulbright-Hays Group project in South Africa, of which I was the co-PI, emphasized the importance and urgency of decolonizing the curriculum, this extends to our research approach. Our distinguished Black Psychologist, Baba Dr. Wade Nobles, talks about a phenomenon that he calls scientific colonization, and explains it as a phenomenon in research practice that occurs when "the center of gravity for knowledge acquisition about a people is located outside of the realities of that people's lived reality". In addition to teaching methodologies, research methodologies related to the study of Africans and the African diaspora need to be rooted in the historical, cultural, and lived experiences of Blacks to be relevant, valid, and reliable. The students who are published in this journal are in the beginning stages of their academic and research careers; they are being trained and mentored through this So Dayi Student Journal project by researcher and professor, Dr. Serie McDougal III, whose research and teaching practice, as well as mentoring approach is grounded in African principles, and this is reflected in students' papers. In investigating health and education in the Black community, the students have considered several other aspects of Black lives as part of their approach, including spirituality, institutional racism, and identity. They challenge the validity and reliability of mainstream diagnostic tools for mental health assessment and present historically and culturally grounded approaches and models we can utilize in research, health, and educational practice to better understand the realities of Black people.

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[1]Wade W. Nobles, *Seeking the Sakhu: Foundational Writings for an African Psychology* (Chicago: Third World Press, 2006), 124.

The Impact of Religion and Spirituality on African American Mental Health and Identity

By Rachael Adeniran

Studies have shown that African Americans and people of color have more religious practices and spirituality than other races (Jackson, 2008). During slavery, spirituality served as a source of meaning and purpose through which African Americans interpreted their lives and experiences. Although there have been disagreements about the importance of spirituality and religion, their definitions overlap. A religion is an organized system of beliefs, practices, and expressions related to, God, Allah, or any higher power. The practices are designed to keep the individual closer to the transcendent or to foster an understanding of their relationships and responsibilities to others in the community (Koenig et al., 2012). Spirituality involves an intimate connection to the transcendent or supernatural, which consists of a feeling or belief that there is something greater than us, something more to being human than sensory experience.

There is an interesting complexity to how racial discrimination and spirituality or religions play roles in the psychological well-being of African Americans. Unfortunately, racial discrimination is a recurring experience for African American youths and adults. By the most conservative estimates, 63.10% of minorities experience racial discrimination, as compared to 29.61% of Whites (Boutwell et al., 2017). Moreover, experiences with discrimination are associated with various health problems involving self-identity, academic performance, and risk of depression and substance abuse. Although a small percentage of Black people have found ways to cope with situations like this, it seems that others inevitably still struggle with them. Given these

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outcomes, the research question of this paper is, “What is the relationship between racial identity and spirituality or religion in the psychological well-being of young African Americans?” This paper addresses several topics: identity, spiritual development, mental health, racial socialization, and Afrocentric and Eurocentric approaches to African Americans. The aim is to help people of all ages understand the roles religion and spirituality play in our identity and well-being, and how we can use spiritual practices to control adversaries and mental issues. The impact of spirituality leads to social and mental transformation in Blacks’ lives and in the mental health field.

Ideologies of Identity

The study of self-concept and identity has played an essential role in the history of African Americans. The popular notion that African Americans suffer from low self-esteem because of their history of oppression has no support. It is crucial to study the reason behind a claim and the relationship between the idea, well-being, and the functioning of African Americans. The conceptualization of the self depends on culture and socialization (Poll et al., 2018). In other words, an individual’s beliefs or feelings about the self can be linked to their social group. Examples of social groups include religious congregations, families, and circles of friends. These groups are agents of socialization that influence identity development and the psychological well-being of individuals. For example, when we look into the lives of a Black or cultured family, we see specific values, including an emphasis on consanguinity over conjugal relationships, respect, responsibility, and spiritual or biological relationships. Religion and spirituality have been pillars of most traditional family relationships. According to Hill (1971), these attributes of an African American family are functional for survival, stability, and improvement. Religious or spiritual parents are more likely to instill their knowledge in their children through everyday interactions, and this remains an agent of socialization. A body of research suggests that adolescent religious participation provides youths with competencies and social and organizational ties (Smith, 2003), which contribute to the children’s well-being and improve their life chances. The beliefs, values,

and knowledge conveyed through religious coaching may or may not shape the beliefs and identities of the younger generation. However, it will primarily affect their choices, perspectives, and identification.

Identity Development

Identity formation begins at birth and continues throughout life. Developing an identity involves personal insights and observations of oneself in a social and religious context. These observations might make one realize specific ways of life and treatment that come with identification. According to Erickson (1950), successful identity development enables individuals to proceed more effectively with life tasks of intimacy and integrity. Developing a sense of religious or spiritual identity may also contribute to these effects. From a psychodynamic perspective (Erickson, 1950), the process of establishing an identity, whether social, racial, or spiritual—involves passing from a period of being unaware of the self to a period of recognizing and forming the self through interaction, and finally to a period of clearly perceiving the self with others.

Spiritual Development

By integrating the psychodynamic perspective on identity, we can see how spiritual identity develops in African Americans' lives. Individuals can develop a spiritual identity through communication with God and by recognizing the divine within themselves and others. Such interactions and recognition can be termed "spiritual experiences," as James (1902) called them. These spiritual experiences allow individuals to construct a spiritual sense of the world they live in and beyond. Religious and spiritual practices from Africa followed enslaved Africans and were merged into an identity to produce unique beliefs and expressions that we see today. By reflecting on spiritual experiences from the past (slavery) and projecting these into the future through faith (Smith, 2016), African Americans could feel a sense of continuity, giving their lives purpose and control.

Spirituality, Religion, Well-Being, and Health

Several studies have shown that following spiritual identity development, various dimensions of spirituality increase well-being, lower depression, reduce illness, and improve mental and physical health and quality of life (Smith, 2007; Garrison & Davis, 2005). Many health professionals and people of color have argued that religion and spirituality play a role in mental health, but some do not agree. This section addresses various effects of religion and spirituality on African Americans' mental health.

Depression

Religion or spirituality can support or sabotage an individual's mental health, depending on the situation. For example, regarding self-esteem, some health professionals have argued that religion and spirituality might increase a person's feelings of guilt, because most religious beliefs and practices focus on individual sin, and this can lead to depression. However, that is not true in most cases. Of seventy prospective cohort studies, 39 (56%) reported that greater religion or spirituality predicted lower depression or faster remission of depression; seven (10%) predicted worse future depression; seven (10%) reported mixed results (both significant positive and negative associations, depending on the religion or spirituality's characteristics; Bormann et al., 2006). An individual in a depressive state can seek spiritual or psychological help, but the results might vary for everyone.

Due to the negative effects of slavery and discrimination, African Americans found comfort and a sense of a new beginning from their intimate connection with God, which led to religious practices and a way of life. Black individuals and other spiritual communities built churches as sanctuaries against oppression to help their families, friends, and communities. Studies have also revealed that people involved in religious practices like prayer, meditation, and Bible studies found ways to channel their suffering into peaceful moments (Hamilton et al., 2013). Religious or spiritual African Americans turn to Bible scriptures in times of struggle to seek inspiration, peace, and comfort. A typical Bible verse that helps with depression, uncertainty, or anxiety is Jeremiah 29:11: "For I know the plans I have for you, declares the Lord, plans for peace and not for evil, to

give you a future and a hope." This verse suggests better days ahead, and that God has a plan for us even if our circumstance are unpleasant and difficult. These are encouraging words that spiritual individuals depend on to carry with them.

Emotions

The specific rules, regulations, and values a religious or spiritually devoted person abides by are claimed to prevent negative emotions and encourage positive emotions such as happiness, satisfaction, hope, inspiration, optimism, and self-esteem. Some people differ on this, but African Americans have shown a high proportion of positive emotions due to engaging in religious practices. Religion is used as an emotional coping strategy to reduce racial stressors. Effective coping strategies include social support (e.g., church, family, and religious leaders) and prayer or religion (Horton & Loukas, 2013).

Other Mental and Social Issues

Spirituality has also been connected to better coping among children in neighborhoods with high violence and crime. Saunders (2000) examined PTSD among 71 African American children between the ages of 9 and 11 from high-crime communities in Houston, Texas. Children with strong spiritual beliefs were protected from the effects of violence and showed fewer symptoms of post-traumatic stress than those without such beliefs. Most religious practices emphasize love and compassion. These prosocial behaviors can suppress stress and reduce antisocial behaviors among children. A study of 104 participants examined the relationship of religion to delinquency and crime. Eighty-two (79%) reported a significant negative relationship, whereas only 3% found a positive relationship (Rhodes, 1970). Religious participants are less likely to be involved in criminal offenses like theft or property damage because of their instilled values.

Healthy Choices

Many people have asked how religion and spirituality affect African American identity because they fail to understand how explicit religious or spiritual practices help nurture and shape who people are. In mid-2010, at least 326 quantitative, peer-reviewed studies examined

relationships with religion or spirituality. Of those, 256 (79%) found only significant positive associations between religion or spirituality and well-being (including eight at a statistical trend level, that is, $.05 < P < .10$). Some rules and practices might seem too strict to some people, but they help in the development of healthy physical, mental, and social habits. One way religion or spirituality influences mental health is in the area of substance abuse. Studies have examined the relationship of alcohol use, abuse, and dependence with religion and spirituality. The most significant share of the studies were among individuals attending middle school, high school, or college. Taking these substances can interfere with one's education, family, and health. Children brought up in households with strong religious or spiritual values were less likely to participate in activities like smoking and drinking, as those went against their values. Hence the protective effects of religion and spirituality may influence people's health choices on such substances.

Afrocentric and Eurocentric Approaches to Mental Health

A doctoral student at the University of Kansas School of Social Welfare, discussing her experiences as a mental health consultant in a brown and Black community, said "Black women experience mental health issues at inappropriate rates but do not get services at the same rates as others." Parker (2021) discussed how the mental health field has had a prolonged shortfall, especially among Black mothers, and suggested an Afrocentric approach. The analysis of the roles of spirituality and religion in improving African Americans' mental health shows an Afrocentric approach to mental health. African Americans with mental illness have sought help. But most Black people have been dissatisfied with their experiences and mistrust health professionals because most are unaware of how great a role culture and spirituality play in their lives. The mental health field predominantly takes a Eurocentric approach to research and treatment, without considering the structural and societal issues that contribute to mental health, such as racism and discrimination. Given this, Black people confine themselves to family, community, and God rather than health professionals. That is why Black churches have long been considered the foundation of the African American community (Lincoln & Mamiya, 1990) and have served as a significant

source of trusted social support.

A Eurocentric perspective holds a rational model of the middle-class White male. This model causes African Americans to be seen as deficient and inferior because not all Americans are suitable for the model (Akbar, 2004). According to Mpofu, a Eurocentric perspective study of African American focused on individualism instead of communism. But for the most part, this does not reflect the characteristics of African Americans, which include family and community. If this aspect of African Americans is not studied, how are people supposed to understand Black lives, let alone find proper treatment?

Conclusion

The evidence provided here shows how spiritual identity development positively affects the psychological well-being of African Americans. Although religion and spirituality are not a remedy for all mental and social illness and problems, their impact on African Americans should be considered.

The knowledge discussed in this paper can be used to improve approaches to Black individuals' health. Even though religion and spirituality are not the focus of psychological treatments, they are relevant to African American well-being. People of color see themselves through their cultures and histories. An Afrocentric approach, Parker (2021) suggested, would include acknowledging the role of cultural, political, and economic oppression and building on the strength of the community. By understanding the role of spirituality in health, mental health professionals can make a difference. If health professionals receive clinical training on spiritual identity development and learn to recognize the patient's source of strength and support from spiritual experiences, they can provide more care and engagement to people of color, boosting their self-esteem and reducing the likelihood of dissatisfaction with the African American experience. More research on the spirituality of African American mental health would advance Black psychology and improve the approaches used in health care to introduce more treatment mechanisms.

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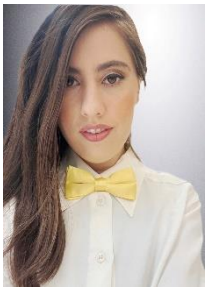
The Impact of Afrocentric Therapy on African American Eating Disorder Patients

By Kimmie Gilbert

Historically, African-Americans have had a complicated relationship with the mental health industry in the United States. Because the U.S. takes a Westernized approach to treating mental illness, African Americans often report feeling misunderstood, being misdiagnosed, and not receiving adequate care. As a result, some people of African descent have developed mistrust that prevents them from obtaining the mental health services they need. And there are relatively few Black mental health clinicians in the U.S., so the cultural competency of other treatment providers is essential. In addition, institutional racism has limited access to mental health services. Some underserved Black neighborhoods do not receive government support to provide high-quality mental health services, and the services that do exist may not be financially feasible for Black patients.

For instance, African Americans are the most underrepresented population of eating-disorder patients. It is not that they do not experience eating disorders at the same rate as their White counterparts, but that stigma and distrust have dissuaded them from obtaining mental health services. Although there is little research into Afrocentric therapeutic interventions for eating disorders, the research that does exist provides a hopeful outlook for successful recovery. Because eating disorders have the highest mortality rate among psychiatric illnesses, it is critical that more research be conducted (Kaye, 2018). This paper attempts to answer the question, “What is the most



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effective treatment for African Americans with eating disorders?" The analysis will cover the spectrum of eating disorders, the importance of culturally relevant interventions, and the impact of Afrocentric models of intervention on African American eating disorder patients.

The Spectrum of Eating Disorders

The most common eating disorders are anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), and other specified feeding and eating disorders (OSFED). Anorexia nervosa is characterized by restricting energy intake, which leads to significantly low body weight, disturbance of body image, an intense fear of weight gain, negative self-image, and lack of recognition of the seriousness of the illness (American Psychiatric Association, 2013). Bulimia nervosa involves episodes of binge eating followed by compensatory behaviors such as vomiting, exercise, fasting, and use of laxatives and diuretics. Like anorexia, BN leads to negative body image, low self-esteem, and feelings of guilt and shame (American Psychiatric Association, 2013). Binge eating disorder is characterized by episodes of binge eating without compensatory behaviors that result in feelings of shame or guilt (American Psychiatric Association, 2013). OSFED involves symptoms of other eating disorders, such as anorexia nervosa, bulimia nervosa, and binge eating disorder that do not neatly fit into one diagnosis, but is not less serious (American Psychiatric Association, 2013).

Although African Americans experience anorexia nervosa "at significantly lower rates" than Whites (Taylor et al., 2007, p. 289), they experience bulimia nervosa and binge eating disorder at "only slightly lower or the same rates" (Mulholland & Mintz, 2001, p. 111). Although many White eating-disorder patients report body dysmorphia (a distorted view of the body) and a perfectionistic drive, it is theorized that because African American culture does not praise thinness, Black patients typically cite other factors, such as trauma and stress, as fueling their eating disorders (Bardone-Cone et al., 2009, p. 356).

The Importance of Culturally Relevant Interventions

Culturally relevant treatment is important for African American eating disorder patients because it can act as a buffer against the desire for thinness that fuels dieting behaviors (Shuttlesworth & Zotter, 2011). Eurocentric beauty standards dictate that the ideal woman is White, thin, and conventionally attractive. By aligning themselves with African culture, Black eating-disorder patients can explore what it means to be of African descent without the pressure to conform to an impossible standard of thinness.

Eating-disorder patients typically report that they view their symptoms as their identity, so it is important that they discover an identity outside of their illness to recover. Because African Americans often do not report symptoms of body dysmorphia and perfectionist drives (Bardone-Cone et al., 2009, p. 356), mental health clinicians often mistakenly develop a treatment plan that involves combatting such cognitions. As a result, Black patients do not see a reduction in their symptoms.

In typical group therapy sessions for eating disorders, most patients are Caucasian. An African American in such a setting could feel isolated and misunderstood, and so less willing to participate in their own recovery. In addition, a predominantly White group or therapist might say something culturally insensitive that causes the African American patient to shut down completely. The Black patient could also be afraid to speak in a group setting, out of stereotype threat, such as the fear of being labeled the "angry black woman" (Small & Fuller, 2021, p. 22)—the stereotype that any Black women who is assertive and expresses her opinion is being angry and overly emotional, so her words hold less value. This example highlights the need not only for more African American treatment providers, but for support groups exclusively for African American patients.

Many non-Black mental health clinicians also may not diagnose African American patients as having eating disorders because they consider symptoms from the DSM IV, which were developed from mostly White populations (Taylor et al., 2013, p. 289). This could cause the patient to doubt her own symptoms, to the point that she does not seek out the appropriate mental health

services. Without treatment, the patient would continue to suffer and be at risk for suicide or death from malnutrition.

Eurocentric models of treatment also do not address cultural issues that affect an African American's sense of identity, such as racism, colorism, intergenerational trauma, and the pressure to conform to "curvy" body standards (Halloran, 2018, p. 45). Racial empowerment can act as a buffer against eating disorder symptoms, so the unique characteristics of an African American patient are not identified, they cannot heal the part of themselves based on having an eating disorder. Racism is a psychosocial stressor that affects African American patients' physical health and is a predictor of bulimic symptoms (Gorden et al., 2010, p. 135). If a mental health clinician does not understand that racism can fuel bulimia nervosa, they may not view processing encounters with racism as important to the patient's treatment. Colorism—the idea that lighter skin tones are more desirable—stems from internalized racism and intergenerational trauma from slavery, which are issues that non-Black mental health clinicians may not understand or feel uncomfortable addressing with an African American patient (DiAngelo, 2018; DeGruy, 2017). Colorism is an extension of African beauty standards, so the patient may feel self-hatred that they cannot live up to those standards and may engage in disordered eating behaviors to cope. Although African culture does not promote thinness, many Black patients have grown up in predominantly White neighborhoods or have attended predominantly White schools and may act out disordered eating behaviors as a way of assimilating (Kempa & Thomas, 2000, p. 17). A patient who is thinner or perceived as "scrawny" by African American peers might also act out specifically in bulimic or binge-eating behaviors as a way to feel more accepted in her community and adhere to cultural norms (Kempa & Thomas, 2000). If these factors that contribute specifically to an African American's sense of worth and self-esteem are not addressed, eating disorder symptoms may continue.

Afrocentric Models of Intervention

If an Afrocentric worldview—a perspective that emphasizes collectivism, spirituality,

kinship, and the liberation of people of African descent (Belgrave & Allison, 2019, p. 50)—is incorporated into an African American patient's eating disorder recovery, she will able to heal the roots of her symptoms. Accordingly, Afrocentric therapy that targets each of these dimensions is the most effective way to treat a Black eating-disorder patient.

To address collectivism, clinicians can ask questions about the patient's community, such as "Is there a sense of community members looking out for each other?" "Are there services that provide support to its members?" "How does your community treat its oldest and youngest members?" "Is there any child monitoring?" and "Do members care about and support the well-being of the community?" If the patient answers "no" to many of these questions which involve core values of African American culture, she may begin to recognize the source of her feelings of alienation that lead her to engage in disordered eating. Feeling like a part of the community is central to African Americans' health and well-being, so the patient may need to take steps to reconnect with her respective community to find healing. The clinician can then create goals involving this issue with the patient as a part of her treatment. The client can take steps to improve her neighborhood, such as volunteering at a community center or lobbying for government financing for local services. This might overlap with spirituality concerns as well, because many Black churches also help the communities they serve (Belgrave & Allison, 2019, p. 322).

If a client comes from an underserved Black neighborhood or from poverty, she may not have had access to good foods and may have developed bulimic or binge behaviors to combat the scarcity mindset (Small & Fuller, 2021, p. 20). In that case, a dietitian could educate the client about nutrition and encourage her to challenge any negative perceptions she has about food.

To address spirituality, the mental health clinician can ask questions such as, "Are there any spiritual practices you adhere to?" "How important is spirituality in your family?" "What does spirituality mean to you?" and "How important is spirituality to you?" If the client reports that spirituality is important to her and her family, the clinician might collaborate with spiritual leaders such as a pastors, ministers, or traditional healers to make sure the patient is receiving spiritual

support in her recovery (Belgrave & Allison, 2019, p. 322). Because many African-Americans use spiritual coping to mitigate stress, attending spiritual services could be beneficial to the client's healing process. In fact, praying activates the parasympathetic nervous system in the body, which elicits a calming effect (Belgrave & Allison, 2019, p. 322). It is critical that the therapist also collaborate with the client's psychiatrist about her spiritual beliefs, because if the psychiatrist has a Westernized perspective on medicine, they may mistakenly diagnose a spiritual issue as a clinical one and provide unnecessary medication (Belgrave & Allison, 2019, p. 322).

The clinician can then learn what the client's family structure or kin relationships look like with questions such as, "What kind of parenting style did your parents use?" "What kinds of roles did family members fulfill?" and "Are you from a single-parent household?" By discovering the strengths and weaknesses that are culturally specific to African American households, the client can either reach a place of acceptance or create goals with her therapist for how to improve these connections, so family therapy is essential. In family therapy, a mental health clinician can act as a mediator to help resolve dysfunctional familial patterns. Many African Americans come from a single-parent households or have experienced authoritarian parenting styles, which can be productive for some but emotionally distressing to others (Belgrave & Allison, 2019, p. 279), so the client may be engaging in disordered eating to cope with this distress.

When addressing the liberation of people of African descent, the clinician can ask, "What did your parents teach you about race?" "Was race an important conversation in your home?" "Was African history important in your home?" "Did you have any encounters with racism?" "How did you cope with those encounters?" or "Are you involved in any Black rights organizations?" The clinician can then focus on healing specific traumas and identify ways that the client can get involved with organizations that promote racial pride. Racial socialization and community activism act as buffers against the effects of racial trauma, so the client can find a sense of collective healing that promotes her individual healing (Belgrave & Allison, 2019, p. 276). By suggesting that the client read works by prominent Black educators, explore her African history

and heritage, and investigate Black rights organizations such as the NAACP and Black Lives Matter, the client can gain a more positive racial identity that can act as a buffer against disordered-eating cognitions and behaviors.

Because some African Americans thrive on activities related to verve and rhythm, art and music therapy are also effective interventions (Small & Fuller, 2021, p.145). Creating songs and artworks about unique cultural challenges and experiences can strengthen racial identity and remind the client that her eating disorder does not define her.

Conclusions

Because African Americans have experienced institutional racism and have often developed a mistrust of U.S. mental health services as a result, special cultural considerations should be made in treating African American eating disorder patients. Although training more people of African descent to be mental health clinicians should take precedence, it is also important to train non-Black clinicians to be culturally competent as well. When therapists, psychiatrists, and dietitians are not culturally competent, the African American patient may feel misunderstood, alienated, and unhopeful about recovery. This could reinforce the factors that already contribute to the patient's eating disorder. Overlooking the unique cultural factors at the root of a patient's eating disorder can even be fatal for the patient. If treatment is tailored to incorporate Afrocentric values such as collectivism, spirituality, kinship, and the liberation of people of African descent, the patient is more likely to recover successfully.

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The Potential Effects of a Psychology Project–Based Learning Program in High School on Afrikan Students

By Amere Wofford

Afrikan people have for years been subject to inhumane conditions in the United States. They have been enslaved, hunted, and stolen. In this paper, I will use the terms "Black," "African American," and "Afrikan" interchangeably to describe people of African descent in America. Numerous events throughout history have had traumatic effects on Afrikan people that still affect their community today. Even though there is a need for mental health help in Black communities, numerous barriers reduce their participation in mental health services.

One of these barriers is the limited number of racially competent mental healthcare providers. Black mental health clients face racial isolation due to a lack of understanding of Black lives in present-day psychology. This racial incompetence can cause a disconnect between the care provider and the client, leading to ineffective treatment (Sager, 1972; White, 2004). One solution is Afrocentric psychology, which can help mental health professionals who are not Black work with Afrikans. Any race can use an Afrocentric approach when working with Afrikan clients, but Black therapists are more likely to understand the cultural context of Black clients and report easier and faster development of therapeutic connections (Goode-Cross, 2016).

The problem is that Blacks make up a small percentage of the psychological workforce. An increase in Black mental healthcare professionals would increase the likelihood of such a

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professional understanding Black clients. This research investigates the impact of project-based learning curriculums on Black students and the mental well-being of Afrikan people, in an effort to answer the question, “Can introducing project-based Afrocentric psychology coursework in predominantly Black high schools increase the number of Black students in psychology?” I analyze the literature on the mental states and employment of Afrikan people in psychology and then address what therapy is the most effective for Afrikan people, and why. Understanding the most effective treatment will show why more Afrikans are needed in the psychological workforce. After this, I analyze possible solutions to the problem of low Black employment in psychology and existing project-based programs. The last topic is existing mental health programs in schools and the flaws in those programs.

Afrocentric Worldview and Psychology

The lack of mental health support for Afrikan people is alarming because of the mental state of Afrikan people. According to the Office of Minority Health (2019), “suicide was the second leading cause of death for Blacks or African Americans, ages 15 to 24.” The office also reported, “Black females, grades 9–12, were 60 percent more likely to attempt suicide in 2019, as compared to non-Hispanic White females of the same age.” So there has been a clear call from the Black community for mental health support. This is why cultural incompetence in mental health services is so dangerous (White, 2004).

Cultural incompetence begins with a lack of understanding of a culture’s worldview. This happens due to differences in culture. One example is the religion and spirituality of African people as compared to others. According to the PEW research center (2020), 97% of Afrikan adults believe in a higher power, which is not much different from the 90% of all Americans who do. The difference lies in what that means and how religion is practiced. Mohamed et al. (2021), who did this research, wrote, “Black Protestants are far more likely to go to a church that has highly expressive worship that includes call and response, shouts of ‘amen,’ spontaneous dancing, jumping, or shouting, and speaking in tongues.” These data show that though other race groups are

religious, they do not practice religion in the same way as Black people. The same difference can be found in all aspects of life. Black people essentially practice life differently from other groups. These differences led Millet et al. (1996) to conclude,

> Black and White Americans should be expected to think, feel, and act differently when experiencing what is commonly thought of as mental health problems, either in themselves or in others because of these differences, when confronted with a mental health problem, they would likely seek help at different points in its course, turn to different sets of resource people, and, to match their cognitions, expect success from different forms of assistance. (p. 240).

This difference is far more than in religion; it's a difference of life. There is just an overall different experience of life as a Black person in America. That is why it is so important to have a mental healthcare professionals who understand that and can relate with clients.

Psychology in which Afrikan values, behaviors, beliefs, and heritage are considered when evaluating patients is called Afrocentric psychology. Afrocentric psychology is essential for handling Black patients. As White (2004) put it

> It is very difficult, if not impossible, to understand the lifestyles of Black people using traditional theories developed by White psychologists to explain White people. Moreover, when these traditional theories are applied to the lives of Black folks many incorrect, weakness-dominated, and inferiority-oriented conclusions come about. (p. 5)

The standard practice of psychotherapy is inadequate when applied to Black clients. Afrocentric psychology should be used on Afrikan patients to achieve the best results. In some research samples, Afrikan people even prefered programs that used Afrocentric approaches (Chipungu et al., 2000). In one, feedback was gathered from 12 drug-prevention programs targeted at Afrikan children. The group observed that Afrikan children liked programs with an Afrocentric approach more than others. Programs with Afrocentric approaches were also seen as more important. The students valued the information more, and that could be seen in the program's perceived impact on

the children and through higher levels of engagement. Students also experienced greater satisfaction with Afrocentric programs. This demonstrates good responsiveness to approaches centered on Afrikan worldviews, which can be beneficial and could yield similar results.

One difficulty is the limited number of culturally sensitive mental healthcare professionals. Sager et al. (1972) described the issue:

> Our current therapeutic programs for the poor need to be reappraised. Services must be made available in forms that will be appropriate and in places that will be comfortably accessible. Methods of engagement that are more deeply rooted in the patient's world, and that reflect his priorities rather than the therapist's, need to be developed. (p. 423)

This problem in current therapeutic programs is where Afrocentric psychology comes in and why it can be so effective. Afrikan people are the best equipped to take this approach to psychology. Many Afrikan therapists have reported understanding of the cultural context of their Black clients and connecting with them faster and more easily (Goode-Cross, 2016). This understanding of cultural context, which is common to Black mental health workers, is a critical component of Afrocentric therapy. By connecting with the client, the therapist reduces the likelihood of premature cancellation.

Comfort is not the only benefit of Afrikan therapeutic dyads, according to Makki (1999): "It is the sharing of dynamics related to being an ethnic minority that produce[s] the increase in identification range and intensity" (p. 68). The understanding of the African world view also makes therapists better able to identify mental dysfunction. This is a large part of why Afrocentric psychology is a necessity for Afrikan life. Afrikan people think this as well, as one report showed that Black clients were more open to therapeutic interventions when they had Black therapists (Sanders et al., 2006). The literature demonstrates that Black mental health professionals work very well with Afrikan individuals.

There are some difficulties with same-race Black therapeutic dyads though, including over-investment on the therapist's part, which can have negative effects on the therapist. There is A

greater understanding and familiarity are sometimes assumed by clients who have Black therapists (Goode-Cross,2016). However, the benefits and drawbacks of a Black therapist–Black client relationship don't all apply to all cases. Some Afrikan therapists may not identify with or understand Black worldviews. Nevertheless, Black therapists are more likely to provide Afrocentric therapy and relate to and understand African worldviews, so an increase in Afrikans in the field of psychology will lead to a higher probability of Black participation in therapy.

An Afrocentric approach can be provided best by Afrikan mental health care professionals in most cases, but there are not many of these. According to the American Psychological Association (2022), 4.24% of the psychology workforce are people of Afrikan descent, whereas 84% are White. That makes it hard for Afrikan individuals to find someone who understands them, while White people can expect 84% of mental health care professionals to understand their worldviews.

It isn't always a lack of understanding causing a disconnect. A White therapist is also working against history. Sager et al. (1972) wrote, "Years of humiliating contact with Whites have taught the Black person not to share his personal feelings with them. Whites do not understand the values of Blacks, and many tend to be judgmental and mocking" (p. 416). These are things Blacks do not have to worry about as much when they have a Black therapist. Sager et al.'s remark is also in line with Good-Cross et al.'s findings of easier connections to Black therapists, because Black therapists don't have this history of antagonism against the same clients. What we need are more Black mental health workers.

Existing Project-Based Curriculums

One possible way to get more Afrikan people into the field of psychology is to introduce gateway psychology programs to predominantly African American schools. School programs have been used for years to get adolescents into specific fields in college. Examples are Project Lead The Way (PLTW) and Mathematics, Engineering, Science Achievement (MESA), both aimed at getting more college students into STEM fields. PLTW is a project-based program with a years-

long sequence of courses in problem solving, design, and technology, from kindergarten through twelfth grade. It includes some AP courses that let students get college credit, enabling a smoother and cheaper transition to college. A survey by Rethwisch et al. (2013) of students in Iowa found that participation in PLTW increased their likelihood of going to post-secondary school by 11%, although it could not be confirmed whether they went into STEM majors. The study also showed an increase in math and science standardized test scores. Data collected on the MESA program showed that the "experiences of the respondents were perceived as making contributions to their sense of self-efficacy in engineering, their perceptions of engineering, and their interests in engineering" (Denson, 2017, p. 89).

The data suggest that similar programs geared towards psychology could increase interest in that field. This, paired with Chipungu's data on Afrocentric programs, demonstrates the potential for an Afrocentric project-based psychology program to increase Black pupils' interest in psychology. A program like these connected to psychology, in a school of predominantly Afrikan children, could also lead to an academic boost. Ideally, the curriculum would include AP courses giving college credit for psychology classes. This program could be beneficial not only to Black students but to all future psychologists, teaching them to respect and to try to understand different worldviews. At the moment, many Black mental health professionals feel there is inadequate training on how to treat Afrikan clients (Goode-Cross, 2016). This course could provide the training that is currently lacking.

One problem with creating programs like this is funding. In 2021, Afrikan people had the lowest median income in the United States (Semega & Kollar, 2022). However, research has found that participation in PLTW had the biggest effect on economically disadvantaged kids (ONE8, 2019). A psychology-based curriculum has great potential for yielding the same benefits. The economic disadvantage that a lot of Afrikan people face affects the funding of their children's schools due to the funding formulas used in different cities. There won't be much money available for these programs because the targeted group is overrepresented in low-income neighborhoods.

That is why it is imperative that the creator of the curriculum be able to onnect schools with grants and other sources of funding. After a school contacts PLTW, the program discusses the price and the grants the school is eligible to receive. Reports have shown that when PLTW had no grant funding, there was significantly lower participation. In Massachusetts, the program went from 9,500 students to 27,500 after grant funding was created (ONE8, 2019). Such grants will be a necessity for schools to participate, but due to the potential, there should be funding.

Existing Mental Health Coursework

As of 2023, there were a few alternatives already in place. In high schools, AP psychology coursework is available. The College Board (2022) described the class's purpose as to "explore the ideas, theories, and methods of the scientific study of behavior and mental processes . . . examine the concepts of psychology through reading and discussion and . . . analyze data from psychological research studies."

There are two main problems with this course for Black students: it is not an Afrocentric psychology course, and it is not project-based. AP psychology is not presented from an Afrocentric or any other minority-centric perspective. This not only makes it less optimal and engaging for Afrikan students (Chipungu., 2000), it doesn't prepare students to handle minority clients. It is also not project-based, something known to help with student engagement and presumably the reason socially disadvantaged children get the most benefits out of PLTW (One8, 2019). It is worth noting that students who take AP psychology have a 0.26 increase in GPA in subsequent course work over students who take introductory psychology courses at a university (College Board, 2022). Psychology coursework in high school can improve performance in post-secondary school. When we pair this information with the benefits a project-based curriculum can lead to, it makes the potential benefits of an Afrocentric project-based psychology program look extremely promising. A project-based Afrocentric psychology program could get more Black students into college and prepare them better for college coursework.

There are also state mandates for mental health–related high school courses in New York

and Virginia. Neither introduced a class or coursework; both added mental health as a component of existing health curriculums (New York State Education Department, 2022; Kaufman, 2018). This was done to make high school students more aware of mental illnesses, what they look like, and good mental health practices. Students who were not literate on mental health had a 60% higher chance of experiencing depression (Lam, 2014), and classes on mental health were shown to increase mental-health literacy and reduce the likelihood of depression.

Even with good intentions, there have been problems with schools incorporating these courses due to different state legislatures. There were stories of school representatives believing that extracurricular activities boost mental health, which led to there being only one class on mental health the entire school year (Mackie, 2019). If schools continue to take this path, it will defeat the purpose of the course and not allow students to gain the mental-health literacy they need. The idea has the right intention, but there is no way to know the effort the school will put in.

To avoid the problems present in other states, the program should be handled by a third party that can devote its full time to making a curriculum and training teachers the way programs like MESA and PLTW do. This program should be available throughout the country, but it must start somewhere. Because the origin of this paper was California, the starting place for the program should be the same. It should be the job of the African studies departments of the California State University and possibly University of California systems. The first school to introduce this sort of program to its community should be the Pan-African Studies Department at California State University–East Bay, University of California–Berkeley, California State University–San Francisco, California State University–Dominguez Hills, or California State University–Los Angeles.

In New York and Virginia, the start of a movement can be seen to get students informed about mental health. The various African studies departments in the CSU should follow this movement and be an example of what the mental health program should look like in California. Then CSU campuses can offer the program to schools similarly to how they offer the MESA

program. The CSUs mentioned are the prime schools for the job because South Central LA and Oakland have the highest populations of African Americans in California (Tamir, 2021). This makes them the prime place to reach African American youths.

The course can also be more engaged with psychology and conversations about mental health, as opposed to being an addition to health class, thus promoting a healthy but academic space for students to learn about mental health. A program like this would allow Afrocentric psychology to be a gateway to the future generation of mental health care professionals. The program could also be expanded into courses on cultural competence in psychology for all cultures.

Conclusion

The data analysis in this paper shows that an Afrocentric project-based psychology course in high school has the potential to increase students' likelihood of going to college, prepare them for college coursework, improve their academic performance and mental health literacy, provide training that is lacking, and increase interest in psychology. Not every African American mental health professional will practice Afrocentric psychology, but they will be far more prone to do so after taking the proposed coursework. These benefits are solely a possibility at the moment, but the existing literature shows that they are achievable and likely.

Other mental health coursework options exists, although none seems to have the same benefits to students as project-based programs like PLTW and MESA have. The people who reap the most benefits from these programs are poor as many Afrikan students are. These findings thus support the thesis and demonstrate that project-based Afrocentric psychology coursework at predominantly Black high schools could increase the number of Black students in psychology.

These findings show the potential for something amazing for Afrikan adolescents, but further research is needed to confirm the benefits and determine the best curriculum. This coursework could teach mental health literacy and Afrocentric and minority-centric worldviews to students of all ethnicities. I believe the benefits are most needed and will be felt the most by

Afrikan people, but the second most affected group will be White people. The coursework could teach future White mental health professionals the cultural awareness needed to diagnose and help Afrikan patients. It could also teach all students mental health literacy, which could improve the spotting of mental illnesses. In multiple ways, this potential program could affect the future of Black mental health.

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Gendered Racism and Mental Health among Black Women

By Ashley Pedraza

Gendered racism consists of structural sexism and structural racism that overlap with health disparities based on gender and race. Black women are a population that have high experiences of gendered racism, which has shown to have detrimental effects on mental health. A lifelong study of Black women's experiences with gendered racism found that "more gendered racism across the lifetime was associated with more subjective cognitive complaints separately through depressive symptoms and disengagement coping" (Hill-Jarrett & Jones, 2021, p. 479). Consequently, there is a cycle of stressors correlated to gendered racism in health care settings that reduce quality of life in the unique situation of Black women.

Perceptions of racism and discrimination-based mistrust in healthcare systems may be the leading factor in Black women's participation in health care. These health services and resources may include mental health and psychiatric services. The system that is supposed to help people cope with emotions and illnesses fails to create a trusting environment. The question this research poses is, "How do experiences of gendered racism affect the mental health and the participation in health services of Black women?" I first analyze the connection between racism and mental health in the African American community, then the unique struggles faced by African American women in maternal care and HIV interventions due to perceptional biases. A connection is then established with adverse experiences affecting mental and cognitive health and leading to physiological illness.

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Awareness and active efforts by medical providers to dismantle institutional gendered racism is necessary for the well-being of these women.

Racism and Mental Health

African American communities face obstacles to well-being, including mental health, with an indicating factor of racism. There is a correlation to the psychic distress in these communities and patterns of racist incidents, and African Americans face more racial discrimination than other ethnic groups. Experiences of racism can have negative psychological and psychosocial effects. Population-based studies of perceived racist incidents have found that discrimination is a predictive factor of mental health status (Bryant-Davis & Ocampo, 2005, p. 483) and of psycho-physiological illnesses such as hypertension. These studies were done to conceptualize racist incidents as traumatic, as racism is a critical factor in psychiatric symptoms in African American communities. In the U.S., ethnic minorities lack access to high-quality mental health care and are underrepresented in culturally sensitive mental health research. African American communities already face obstacles to physical and mental health care access through discrimination, and African American women face a more layered, intersectional experience. Hence misinformation and lack of resources leave these women with a higher propensity to illness, and they are neglected by the same healthcare system that refused to educate them on those illnesses.

Gendered Racism Experiences in Health Services

Childbirth is one common traumatic experience for Black women that overlaps with gendered racism. Women of color are more likely to describe their childbirth experiences as stressful and neglectful (Markin & Coleman, 2021), and Black women are more likely to describe prenatal care as stressful. One explanation is that the healthcare system holds gendered racial stereotypes and biases (Markin & Coleman, 2021). As evidence that this is related to race and not socioeconomic status, Black college-educated women in New York are more likely to suffer complications during birth than non-educated White women are. Disparities in socioeconomic

status may also be at play, but such studies demonstrate that race has the upper hand.

One stereotype healthcare providers may hold is that Black women are aggressive and dominating. This perception can lead to bias and to the patient being uncomfortable disclosing health information or the provider having a misunderstanding.

A more dangerous misconception, and one that leads to higher maternal mortality, is the perceptions that Black women have a higher tolerance for pain. Symptoms reported by these women are often dismissed or minimized when they may be indicators of serious complications. These dismissive and ignorant attitudes toward Black women are a health disparity based on race, as demonstrated by the case of Shalon Irvings, an African American woman with two doctorates who died shortly after giving birth. Irving's symptoms had been dismissed just days before her death (Adebayo et al., 2021).

Structural barriers in the healthcare system also contribute to health disparities, such as approaches to maternal care. The biomedical approach to maternal care objectifies African American women's maternal experiences, as it is insensitive to their racial identities and realities. In an interview from the study by Adebayo et al. (2021), Beth described how her choice to have a home birth was scrutinized by her doctor. Home births or natural births are more traditional to Afrocentric approaches of maternal care, which the biomedical model rejects. Beth also explained that she felt that her doctor became inconsistent and labeled her "high risk" after learning of her preferred birth method (Adebayo et al., 2021, p. 1140).

Another misconception is the health care industry is the wrongful accusation of Black women of having inherently poor health and being irresponsible with their health. In interviews, African American women shared their experiences of being told to take medications on the basis of which diagnoses were common to African American communities, rather than of their individual histories (Adebayo et al., 2021). This also diminishes women's ability to make informed decisions about their own bodies and invalidates their competence as individuals. The lack of racial realities in maternal health care is an example of how institutional racism normalizes these experiences

under standard practice. Insensitivity to African American realities are one explanation of why Black women are more likely to have negative experiences with maternal care in U.S. institutions (Adebayo et al., 2021), which are one reason that Black women develop distrust of health care.

One region where structural racism and discrimination are historically prominent, the Southern United States, also has significantly higher cases of HIV. At an intersection of gendered racism, Black women have the highest rate of new HIV diagnoses among all women (Randolph et al., 2020). Low incomes, low-quality health care, and low insurance coverage systematically lead to elevated risk of HIV because of the high population of women of color who live in poverty. Socially, there is not much advocacy or support for the underexamined population of Black women who contract HIV.

Medical mistrust among Black women is one factor in poor HIV prevention and treatment. It is also correlated with lower confidence in and adherence to treatments (Randolph et al., 2020). And this study found that perceptions of medical mistrust among Black women was a determinant of participation in HIV prevention programming. There are few HIV interventions for the unique intersectional needs of Black women's identities. An analysis of group studies of Black women's perceptions of institutional racism, found that lack of effective communication by healthcare providers to be a consistent theme in conversations about medical mistrust and structural racism (Randolph et al., 2020). Another common theme was previous clinical experiences, suggesting that clinical settings were considered trustworthy or not on the basis of reciprocity toward Black patients. The study demonstrated that Black women feeling more empowered in clinical encounters is one way to improve their participation in health care.

Medical mistrust leads to people not listening to healthcare providers and to behaviors that harm health. Woman who felt empowered to question providers and express their skepticism improved their communication with providers. Others related experiences of having to do research on their own, such as on birth control options, because the information they were given lacked depth. These women described a need for health literacy, as the medical advice given to them was

described as “White terminology” (Randolph et al., 2020, p.601). Understanding is critical for the participation of Black women in health care.

Black women also face the barrier of inequitable health care. In lower-income communities, these women face limited resources for health care due to systematic inequalities that limit affordable participation in healthcare services (Randolph et al., 2020). This barrier does involve economic factors, where the other had race and gender as the dominating indicators of discrimination.

Another reason for the substantial risk of HIV and detriment to overall wellbeing is unfortunately the high levels of intimate partner violence Black women face. Women of color face the highest rates of sexual violence, and Black women have the highest percentage of reported sexual and physical violence and psychological aggression from partners (Sharps et al., 2019). Intimate partner violence also leads to an increased risk for sexually transmitted infections, but it also prominently shows how factors such as poverty, high unemployment, spiritual values, racism, and sexism affect their seeking treatment and justice. These women are at risk for many psychophysiological problems due to economic and social conditions, such as community norms and stigmas that enforce gender-power imbalances, misconceptions about condom usage, and unsafe sexual encounters. Black women may feel reluctant to disclose their sexual health status out of fear of violent repercussions, fear of scrutiny, or the unwillingness of their partners to seek treatment. Transgender Black women specifically experience greater sexual violence due to transphobia (Nemoto et al., 2020). These dangerous sexual behaviors put these individuals at an elevated risk of sexually transmitted diseases and other physiological harm. However, the behaviors are not due to inheritance or racial identity; they are reactions to psychophysiological stressors from society’s treatment of Black women.

Effects of Racial Stress on Mental and Physiological Health

Lack of access to care and medical mistrust prevent Black women from making use of many prevention and treatment services, including mental health services. The inability to be

physically healthy and the development of other medical concerns may contribute to prolonged stress, which affects mental and physical health and vice versa. An example of a cognitive illness affected by overall health is Alzheimer's. Prevention is crucial, as degenerative diseases have no known cure. Lifestyle is a major contributor to the development of cognitive diseases, and studies have shown that lifelong experiences of gender-based racism may have an impact. Black women are at a substantial risk of Alzheimer's and of rapid cognitive decline in old age (Hill-Jarrett & Jones, 2021). Cognitive diseases are due not just to age but substantially to lifestyle factors.

One study of racism and subjective cognitive ratings among older Black women found that higher levels of racism lead to 2.75– 4.00 times the risk of a poor cognitive rating, (Hill-Jarrett & Jones, 2021). Cognition is affected by mood and depressive symptoms. Such symptoms may precede a decline in memory functioning, hence the higher risk for Alzheimer's and cognitive decline. The study also linked higher depressive symptoms from perceived stress to poor episodic memory. Increased encounters with gendered racism over the lifetime were reflected in increased depressive symptoms, meaning more subjective cognitive complaints, such as continuous perceived stress and lack of support leading to depression.

This racial stress, however, can also have an impact on the physical health of Black women. Another study linked discrimination-based experiences to higher risk of cardiovascular diseases (Hill-Jarrett & Jones, 2021). The contributing factor was Black women's coping style. Whether the coping method was spiritual, social, problem-oriented, or disengaged, increased high-effort coping was linked to lower blood pressure. High-effort coping and high social support also led to lower levels of perceived racism and lower blood pressure (Hill-Jarrett & Jones, 2021).

This study was conducted on English-speaking self-identified Black American women at least 50 years of age. Some crucial factors to consider from this study include the fact that gender identity was reported rather than biological sex, and a medical histories excluded neurodegenerative diseases, ADHD, and learning disorders. These factors are relevant, as there may be unique reasons for higher or lower reports of discrimination throughout the individual's

life. However, the gendered racism was measured through questionnaires that asked about treatment related to being a "Black woman" (Hill-Jarett & Jones, 2021, p. 485).

Approaches to Health Disparities

The gender-based racism experiences of African American women are neglected, in the sense that there is little advocacy for improving these experiences. As mentioned above, one way to build trust in medical providers is by empowering Black women. The threat of racial bias can be a motivation for these women to question health recommendations and ask for more from their providers. However, this study suggested bringing awareness to providers about the role they play in the cycle of medical mistrust and miscommunication. As the study was related to lower-socioeconomic Black women, in an attempt to understand strategies to shield them from HIV and maximize resources for those living with HIV, its suggestions included integrating meetings on race, trust building, and implicit bias as a step to modifying providers' behaviors and institutional discrimination in HIV programming (Randolph et al., 2020). This awareness on part of the providers relates to empowering Black Women by improving communication and interactions between patients and providers.

There is also a need for solution-oriented research on reducing stress related to such health disparities. One article addressed how mind-body interventions may be useful for the unique stressors of African American women. The NTU psychotherapy intervention is one example of a culturally sensitive approach to well-being and spirituality. As a framework, it has been used for programming substance abuse treatment, family counseling, and clinical behavioral care. The approach is based on environmental awareness, as African American women must learn of psychological barriers, self-barriers, positive self-regard, promoting balance, and cultivating calmness (Woods-Giscombé & Black, 2010). Spiritual tasks such as praying, meditating, and nature study are part of the therapeutic experience. African American targets are relief of feelings such as needing to be self-sufficient, neglect of self-care, fear of vulnerability, and emotional suppression. It may also help these individuals to work past undesirable interpersonal experiences,

and reframe strength to engage in self-care behaviors. In respect to Afrocentric worldviews, the NTU approach includes behaviors that nurture both the individual and the family.

Conclusion

Experiences of gendered racism have a multitude of negative effects on mental health and can lead to psychophysiological health problems. This research looks at social factors such as racial and gender discrimination in healthcare that lead to a cycle of health inequities, such as higher vulnerability to preventive diseases and higher mortality in maternal labor and post-care in the Black community. These disparities then lead to inequitable access to health care and to balanced emotional, physiological, and cognitive well-being. Therefore, it is important to acknowledge the unique experiences of African American women with health disparities based on gender and race to better support their health, improve their quality of life, reduce discrimination, and rebuild the trust that is lacking toward the medical community.

Awareness of these issues in medical institutions is crucial for dismantling medical mistrust and improving medical advice. There are reasons to accommodate cultural sensitivities when it comes to conditions that are easily preventable. For instance, empowerment and the perception of medical providers advocating for Black women lead to trust of providers. More research is also needed that is specific to African American communities and African American women, to understand the different approaches and efforts to provide resources and cultural sensitivity.

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