CHAPTER 1

Women of Color's Mental Health Matters: *Mujeres de Color, en la Lucha* (Women of Color, in the Struggle)

It is a struggle being a Woman of Color in the United States, where race and gender are powerful determinants of life experiences. Many Women of Color today carry the weight of centuries of adversity, beginning with the stark exploitation of African peoples in more than 250 years of slavery and extending through the postslavery era of Jim Crow and into present-day institutionalized racism, sexism, classism, and heterosexism. Throughout these eras, Women of Color's social, political, and economic contributions to the United States have been undercompensated and undervalued.

Compared with White and Asian women, Women of Color are among the most likely to be affected by adverse social, political, and economic conditions such as poverty, underemployment, joblessness, incarceration, homelessness, and lack of access to basic health care. In 2017, Women of Color experienced higher poverty rates and were paid less than their White counterparts for the same work (Institute for Women's Policy Research [IWPR], 2017; U.S. Census Bureau, 2015). When working full time, Black women earn just 62.5 percent of White male median earnings and 87.5 percent of Black male median earnings (IWPR, 2017). The difference is less among women; Black women's median weekly earnings ($671) were 82.8 percent of those of White women ($810). Overall, median weekly earnings of Hispanics ($675) and Blacks ($696) were lower than those of Whites ($911) and Asians ($1,066) (Bureau of Labor Statistics, 2016).

Proportionally, Women of Color are enrolled in college at a higher rate than any other racial–gender group (9.7 percent versus 8.7 percent for Asian women and 7.1 percent for White women). Unfortunately, although Women

of Color may be earning degrees at a disproportionate rate, recent data have shown that at all educational levels, Women of Color are concentrated in lower-paying jobs than Black men and White men and women (IWPR, 2017). Moreover, the socioeconomic and employment conditions of Women of Color influence access to health and mental health insurance and, therefore, health care. Women of Color have lower rates of health insurance coverage (approximately 83.5 percent compared with their White female counterparts at 89.8 percent; IWPR, 2017), and when they do receive health care, their quality of care is lower than that of White women and men (Office of Research on Women's Health [ORWH], 2014).

In addition to socioeconomic status, *acculturation*—the process of psychological and behavioral change that people undergo as a consequence of long-term contact with another ethnicity or culture—plays a significant role in the incidence of mental health conditions and access to health care. Discrimination, prejudice, and exclusion (based on language, skin color, economic class, or other factors), perhaps for the first time, present Women of Color (and all People of Color) with the predicament of identifying with a newly acquired "minority" status. This perception can often affect health- and mental health–seeking behavior as well as disparities in receiving efficient and effective care. These economic, educational, contextual, and social inequalities have often exacerbated or even created mental illnesses or concerns among Women of Color (ORWH, 2014).

MENTAL HEALTH

It is important to define the terms "mental health," "mental illness," and "mental health concerns" as used in this book.

- *Mental health* is defined as a state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community. The positive dimension of mental health is stressed in the World Health Organization's (WHO's; 2003) definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (para. 1).
- *Mental illness* refers to a wide range of mental health conditions—disorders that affect one's mood, thinking, and behavior. A few examples of mental health disorders are depression, anxiety, drug abuse or addiction, schizophrenia, and eating disorders.
- *Mental health concerns* may show up as signs and symptoms that impede one's everyday life, such as feeling sad or down; reduced ability

to concentrate; excessive fears or worries; extreme feelings of guilt; extreme mood changes; withdrawal from friends and activities; problems sleeping; inability to cope with daily problems or stress; alcohol or drug abuse; major changes in eating habits; and excessive anger, hostility, or violence (American Psychiatric Association, 2013). In fact, signs or symptoms of a mental health concern sometimes appear as physical problems, such as an upset stomach, back pain, headache, or other unexplained aches and pains. A mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect one's ability to function (WHO, 2003).

WOMEN OF COLOR'S PSYCHOHISTORY

As James Baldwin (2010, p. 154) said, "History is not the past. It is the present. We carry our history with us." Women of Color who possess a spiritual or mystical consciousness know that the past reverberates in the present and the future. Hence, when we speak of mental illness and wellness among Women of Color, we must begin by understanding how the traumatic experiences of slavery have been passed down through the generations. The historical wounds of enslavement, conquest, and colonization continue to have an impact on the psychological health of Women of Color, even if their familial origins are outside the United States. A major link between Latin and Black communities is that both groups were forced to migrate to the United States for economic, political, environmental, and social reasons for the purpose of cheap labor (Gutierrez, 1990). Because they were forced to live in the United States and leave behind their extended families, communities, and culture, they suffered psychic injury, compounded by the patriarchal, racist structure of the United States.

Jenkins (1993) discussed how, under the U.S. slavery system, African American women's "survival was dependent on this oppressive institution, which exploited her biological reproductive capacity, required her to work, care for, and live through others despite her own needs and constant subjection to social male toxic violence, resulting in trauma" (pp. 119–120). During slavery, this role was adaptive for survival, but it also required a connection to the oppressor and a disconnection from the self. For instance, enslaved women were forced to comply with sexual advances from their masters on a regular basis. Consequences of resistance often came in the form of physical beatings, being sold off, and, at times, death. Thus, slave women often dissociated from their sexual and physical selves to survive the demonic conditions of sexual exploitation or violence.

A present-day resonance of this adaptation may be seen in the mythology of the "Strong Black Woman" (SBW) who is selfless and all-giving of

her body, her emotions, her skills, and her labor (Mullings, 2006; Woods-Giscombé, 2010). Today, many Women of Color continue to rely on this adaptation for a sense of survival in continuous and unpredictable hostile environments. An example is the online harassment of and threats toward Women of Color. Although not a new phenomenon, the degree to which these are directed at Women and Girls of Color has increased. For instance, racism and sexism can blend together in the mind of the harasser and be displayed as an inseparable whole. The types of statements used and actions taken incorporate the unique characteristics of Women of Color, subjecting each race and ethnicity to its own cruel stereotype of sexuality. As discussed earlier, harassment of African American women may incorporate images of slavery, degradation, sexual availability, and natural lasciviousness, whereas although harassment of Latina women may also include images or microaggressions pertaining to servitude, they may also be seen as hypersexual or hot headed or be sexually fetishized. This subjectivity often creates a continuous state of emotional trauma that disrupts the ability to develop effective coping strategies (Lewis & Grzanka, 2016).

Forms of online harassment can vary, from racialized or sexualized name calling to persistent stalking and outright threats of sexual and personal violence. It remains the case that the wide-open environment that enables creativity and innovation online also enables derogatory and sometimes anonymous speech against which Women and Girls of Color often have no recourse. An Indigenous colleague shared one of her experiences with online harassment via a post on her Facebook page:

> Just read an article of yours re aborigines don't get a free ride. So why when I join a gym or go to any government department they ask if I'm indigenous and to tick a box. As a white person I find this so racist and discriminating. What has joining a gym got to do with my race unless there are some freebies.

She spoke about this posting with rage and frustration, stating, "as an educated and privileged woman you'd think I could 'brush my shoulders off.'" Further referencing the words of the rapper Jay-Z—"If you feelin' like a _____, go and brush your shoulders off/Ladies _____ too, gon' brush your shoulders off/Get, that, dirt off your shoulder"—she responded, "I can't brush it off; it festers." This is one example of the daily harassment Women of Color may experience on social media in regard to their race, gender, or both.

A Woman of Color is socialized to believe that everyone else's well-being matters more than her own. She suppresses her dreams to assist in fulfilling those of others around her; she thrives on being the most obedient, solid rock of a servant possible (Abrams, Maxwell, Pope, & Belgrave, 2014; Beauboeuf-Lafontant, 2009). For instance, many Latina women are also often

characterized as submissive, self-denying, and self-sacrificing for the sake of those they serve. In the family environment, the ideal Latina woman is one who places the needs of her children and husband first and asks little for herself in return (Gutierrez, 1990). Experiencing this continuous state of emotional trauma eventually disrupts Women of Color's ability to develop effective strategies to respond to stressful or traumatic events (Abrams et al., 2014).

This cultural bond translates into gender relations and roles, called "machismo" and "marianismo," which call for distinct gender roles for men and women. "Machismo" (similar to male chauvinism) refers to characteristics of the male that include dominance, virility, and independence; "marianismo" refers to characteristics of the female as submissive, chaste, and dependent. Traditionally, the Latino man is the economic provider and the Latina woman is responsible for the domestic roles, most notably, caretaking of the children. Machismo-based family relations can inhibit Latina women from being considered truly equal to Latino men (T. Brown & Smith, 2009). As a result, Latina women can become increasingly alienated from their emotions and cover their humiliation and shame with anger, substance abuse, and depression.

SNAPSHOT OF WOMEN OF COLOR'S MENTAL HEALTH

In recent years, some progress has been made in acquiring a public platform for Women of Color with mental illness. For example, Women of Color celebrities such as Kerry Washington, Taraji P. Henson, Eva Mendes, Alicia Keys, and Gina Rodriguez have shared their personal experiences with mental health issues and stressed the importance of seeking treatment. But there is still a long way to go. The push for health care access under the Obama administration spawned a greater awareness of the role of ethnicity and race in the provision of appropriate mental health services for Women of Color. Until recently, research on mental health services did not consider race or ethnicity (U.S. Department of Health and Human Services [HHS], 2001). The development of research-based recommendations to improve access and utilization has been hampered by the lack of racial and ethnic minority representation in treatment and intervention studies (H. W. Neighbors et al., 2007; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Thus, any bearing that race and culture may have on the manifestation, perception, recognition, and salience of psychosocial symptoms and substance abuse risk factors continues to be overlooked in service utilization research (T. A. Davis & Ancis, 2012; Ono, 2013).

According to HHS (2001), Women of Color are 20 percent more likely to report serious psychological distress than their White counterparts. Moreover, they report an average of 4.7 days per month of poor mental health in terms of managing stress, depression, and other emotional problems

(Melfi et al., 2000). Fewer than 9 percent of U.S.-born Latinas and Caribbean American women seek care in mental health settings, and fewer than 20 percent seek such care in general health care settings. Immigrant Latinas and Caribbean American women are even less likely to seek mental health treatment. However, African American women are more likely than Latinas to receive treatment for depression (Alegría et al., 2002).

The fact that mental health symptoms or signs of distress often manifest as somatic symptoms among Women of Color also calls for attention. Research has shown that Women of Color have high rates of poor physical health outcomes as a result of psychological stress, much of which goes undetected. Many poor health outcomes experienced by Women of Color may either be created or exacerbated by repressed anger and stress related to a sense of powerlessness (S. A. Thomas & González-Prendes, 2009). For instance, several independent risk factors have been identified, ranging from physiological factors such as diastolic blood pressure and immune disorders (Artinian, Washington, Flack, Hockman, & Jen, 2006) to psychosocial factors such as chronic stress (Grote, Bledsoe, Wellman, & Brown, 2007) and a lack of social support (Lincoln, Chatters, Taylor, & Jackson, 2007). J. Jackson et al. (2007) have suggested that coping with structural barriers and racial bias may be a common underlying cause of stress-related mental illnesses, such as mood and anxiety disorders (Lawson, Rodgers-Rose, & Rajaram, 1999; Nuru-Jeter et al., 2009; D. R. Williams, 2000). According to Geronimus, Keene, Hicken, and Bound (2007), the psychological and physiological responses to stress experienced by many People of Color over their life course may lead to chronic physical and psychological health problems, such as high blood pressure, heart disease, diabetes, and lupus.

Very little attention has been paid to the prevention and treatment of Women of Color's health, specifically mental health, psychosocial stress, and illness (HHS, 2001). A full understanding of these multiplicative risk factors based on negative health and mental health outcomes is elusive. Compounding the issue is the fact that Women of Color are less likely to seek treatment for mental illness than their White counterparts (Alegría et al., 2002; Matthews & Hughes, 2001; Neal-Barnett & Crowther, 2000). When Women of Color with psychosocial difficulties do seek help, it has traditionally been through informal sources such as family, friends, and clergy (Glass, 2012; Nadeem, Lange, & Miranda, 2009).

Although several outcome studies have examined Women of Color's mental health treatment and the barriers to that treatment, few have explored their experiences and perceptions of these barriers. Research has indicated that racial, gender, class, and sexual identity differences are important factors to consider in the design of mental health treatment services Ehrmin, 2005; HHS, 2001; Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, 2003; Wallen, 1992; Weiss, Kung, & Pearson, 2003), yet little attention has been paid to cultural

variations, which may have important implications for strengthening service provision for Women of Color.

Several barriers to treatment engagement for Women of Color with mental illness have been identified. These barriers may include shame and stigma, cultural and language differences, fear and distrust of the treatment system (which is based on White middle-class values and perceptions of [biases against] People of Color), lack of information, and lack of medical insurance and transportation (Bowie & Dopwell, 2013; Choi & Gonzalez, 2005; Nadeem et al., 2009; Snowden, 2001). These barriers often prevent Women of Color from receiving proper support or treatment. Latina and Black women are more likely than White women to report stigma concerns as a reason for not seeking mental health services (Alvidrez & Azocar,1999; Cooper-Patrick et al., 1997). Similarly, Caribbean American immigrants report concerns about being labeled "crazy" (Schreiber, Stern, & Wilson, 1998), which reduces their willingness to seek and engage in mental health services (Edge, Baker, & Rogers, 2004; Keating, Robertson, McCulloch, & Francis, 2002). This negative perception of help seeking must be eliminated if Women of Color as a community are going to help people who live with mental health disorders to heal—emotionally, physically, and spiritually. As shared by a Woman of Color client during a focus group,

> So, it would help more to reach out to those who are struggling with depression, and have a little compassion about it. Don't put labels on them, you know. Everybody's got a label. "Oh, she crazy" [while motioning with her finger], "He acting just like a crack-head. Oh that's an addict." You know what I'm saying? Or "She's on welfare, you know," or "She ain't never going to be nobody." This stigma got to stop. Stop labeling people with mental illness, and people got to stop accepting labels, too.

If People of Color are not able to take care of themselves, their families, and their communities and find ways to cope in a healthy manner, many of these negative messages are internalized without their being aware of it, causing damage to their spirits.

Another barrier to seeking and receiving counseling identified by Women of Color is the mental health profession's assumption that all women are alike, as are all Women of Color. The danger is that therapists and researchers will overgeneralize and overlook the tremendous within-group variability. Therapists must take into account ways in which Women of Color experience racial, sexual, and economic bias and bigotry and how their experiences may be different from White women's and men's experiences. Moreover, therapists should understand that not all Women of Color experience these oppressions similarly, nor do they manifest the psychological consequences of these oppressions similarly.

Moreover, when Women of Color do seek professional mental health services, they are more likely than others to have reached a crisis point and are more likely to be misdiagnosed by the therapist or provider (Carrington, 2006; T. A. Davis & Ancis, 2012; H. W. Neighbors et al., 2007). In addition, they may prematurely withdraw from treatment because their ethnic, cultural, or gender needs go unrecognized or they are mistreated because of their race or gender (Blazer & Hybels, 2000; C. Brown & Palenchar, 2004; T. A. Davis & Ancis, 2012; H. W. Neighbors et al., 2007). One consistently highlighted shortcoming is that treatment interventions lack cultural relevance and are inadequate to meet the specific needs of Women of Color (Comas-Díaz & Greene, 1994; Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, 2003; L. V. Jones & Warner, 2011; Miranda & Cooper, 2004; HHS, 2001). In fact, President George W. Bush's New Freedom Commission on Mental Health (2003) described in detail the gender, racial, and cultural problems associated with access to and utilization of mental health and drug abuse services, concluding that the higher burden of mental health disability among racial minorities may be attributed to treatment barriers (for example, access to a provider, cost, culturally relevant services).

In addition to culturally endorsed coping strategies, an understanding of specific barriers to therapeutic service utilization will aid researchers and clinicians in developing culturally relevant interventions, as well as treatment engagement and retention strategies that will meet the needs of this growing population. An important goal of practitioners must be to attend to individual and societal stressors, especially those influenced and exacerbated by experiences of discrimination, oppression, and mistreatment in an effort to promote positive mental health outcomes (Borum, 2012; Conner et al., 2010; T. A. Davis & Ancis, 2012; Neal-Barnett & Crowther, 2000; SAMHSA, 2012; HHS, 2001). The conflicted relationship that Women of Color have with the institution of therapy is also noteworthy. For many Women of Color, being in therapy means that they have failed in their role as (super)women. Moreover, Women of Color come to therapy viewing themselves as the problem versus having a problem.

These challenges and barriers may suggest that mental health providers seeking to engage Women of Color in therapy, often referred to as "wellness work," must use sources of knowledge beyond the canon of mainstream psychology. This work requires therapists to engage in a systematic analysis of the oppressions and liberation processes of Women of Color from an ecological perspective. Hence, understanding the intersectionality of Women of Color's identities and perceptions is critical in the therapeutic process. In partnership with the client, the therapist can explore the story of the Woman of Color who is sitting in the room, develop trust, and establish the goals of therapy. This process will help to promote self-actualization, empower self-growth,

improve relationships, and reduce emotional suffering (L. V. Jones & Warner, 2011). Hence, a Black feminist therapeutic strategy may help Women of Color redevelop or strengthen their historical identity as a means of empowering them to change the conditions that produce their societal understanding of themselves as failed. Moreover, they engage in a healing process that empowers their sense of self-efficacy in achieving life outcomes and goals.

BEYOND THE DATA

Although history and empirical studies have demonstrated that Women of Color are disproportionately more likely to experience life events that increase their chances of having a mental illness, they raise the following questions: (a) Why do so many Women of Color suffer in silence? and (b) How can mental health counselors engage with them, build trust, and help them with their struggles when they have convinced the world that they are strong and do not need help? To answer these questions, we need to understand how Women of Color have traditionally dealt with mental health struggles. By and large, their struggles involve coping with difficulties in isolation, not reaching out to trusted friends and family members, being afraid to ask for help, being too ashamed to seek help, not knowing where to seek help, neglecting their own needs while taking care of others, hiding behind their pain, dismissing the help that professional treatment could provide because of perceived and real bias, and not being able to access therapeutic service because of a lack of insurance or lack of treatment in their region. Women of Color must come to terms with their sense of powerlessness over mental health issues and accept them as temporary so they can receive an optimal level of support. Women of Color must give themselves permission to heal.

CHAPTER QUESTIONS

1. How might social, economic, and contextual factors influence Women of Color's health and mental health status?
2. What are the barriers for Women of Color who seek professional mental health treatment? How do these barriers resonate with you personally?
3. How does current popular culture affect the mental health awareness of Women of Color and contribute to ending stigma?