

Research Article

A Qualitative Exploration: Black Women Living with DepressionKamesha Spates ^{1,*}, Siobhán Hicks ², Bethanie Mauerman ², Na'Tasha Evans ³

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Studies show Black women exhibit distinct depression symptoms and treatment experiences compared to other groups, often facing underdiagnosis and inadequate care. Unfortunately, knowledge about Black women with depression has been underexplored. Therefore, the purpose of this study is to gain a better understanding of Black women's experiences living with clinical depression. To address this objective, we conducted a survey among 28 Black women aged 18 years and older (mean age = 35) residing in the United States, utilizing open-ended questions administered through Qualtrics. The data was analyzed using a thematic analytical approach to identify emerging themes. Three primary themes emerged from the analysis (1) The Legacy of Scientific Racism, (2) Profiling and Underdiagnosis in Healthcare Settings, and (3) Stigma at the Crossroads of Community and Care. These results indicate a pressing need for healthcare providers to offer culturally appropriate services and to focus on eliminating racism and discrimination within patient care.

Keywords

Black women; clinical depression; lived experiences



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1. Introduction

Mood disorders, including depression, are among the most prevalent mental health conditions diagnosed in the United States. Depression can significantly affect the daily functioning of individuals who have been diagnosed [1]. Recent estimates highlight that one in ten Americans experienced at least one major episode of depression within the past 12 months [2]. Additionally, depression is a growing concern in the Black community. While prevalence rates are lower among Black individuals (24.6%) compared to White individuals (34.7%) in the United States, Black individuals suffering from depression tend to struggle with more persistent symptoms [3].

There is a large body of scientific evidence that offers insight into the lives of those most often impacted by depression. According to data from NAMI, women were more likely than men to report experiencing depressive symptoms [1]. Estimates suggest that 21.8% of women reported experiencing depressive symptoms within the past two weeks, compared to only 15% of men. Additionally, those aged 18 to 29 reported the highest symptoms; the next highest age group was those aged 45 to 65 [4].

A further dive in the research revealed that researchers exploring depression in Black women often fail to report whether they are working with non-clinical samples, which could limit the generalizability of the results to clinically depressed Black women [5, 6]. This is problematic given that recent studies have highlighted Black women's experiences with gendered racism, often on a daily basis. Recent research shows that Black women often face gendered racism, a term introduced by Philomena Essed to describe the intersection of racial and gender oppression affecting women in subordinate positions. This unique form of discrimination raises Black women's risk for mental health issues, especially clinical depression [7, 8]. Additionally, elevated levels of depressive symptoms have been linked to disability, disease burden, and a diminished quality of life [7]. Thus, we argue the need to better understand the intricacies of clinical depression in the lives of Black women in the United States.

Therefore, this study aims to better understand Black women's experiences living with clinical depression, which is diagnosed by a licensed mental health provider. To do so, directly fill this knowledge gap by explicitly focusing on a sample of clinically depressed Black women in the United States. Our aim is to produce scientific insights that deepen our understanding of how clinically depressed Black women in the United States experience life, especially compared to Black women who self-report depression or are currently experiencing a depressive episode. Furthermore, this research offers a historical analysis of the subject by examining the impact of systemic barriers and cultural influences on Black women's engagement with mental health care. The ultimate goal is to produce evidence that informs the development of culturally sensitive interventions and supports improvements in clinical care for Black women affected by depression. The following sections present a review of existing literature, emphasizing key evidence-based complexities associated with being a Black woman living with depression.

1.1 Help-Seeking Behaviors for Black Women

Decades of research affirm that mistrust of the healthcare system among Black Americans [9]. These pervasive beliefs are primarily due to the longstanding mistreatment of minoritized groups in the United States [9]. Unfortunately, higher levels of mistrust contribute to a lower likelihood of involvement among Black Americans in participation in preventative screenings and utilization of the healthcare system more broadly [10, 11].

In terms of treatment, provider mistrust has resulted in poor adherence related to depression treatment among Black women, particularly when taking medication [12]. Instead, Black women are more likely to mask depression symptoms, self-medicate, or report discomfort in sharing information about their health [13]. Consequently, decades of research have shown that treatment delays among Black women can be attributed, at least in part, to their distrust of the healthcare system.

Ward and colleagues examined experiences with depression among Black women over the age of 60. Their study found that older Black women consider depression a normal reaction to difficult life situations (rather than an illness) but do not feel the need to seek professional help [14]. Although Black women report more depressive symptoms and express a willingness to engage in treatment options with a provider, mental health services remain underutilized by this population. As these services are underused, Black women face an increased risk of experiencing psychological distress [15].

1.2 Cultural Stigma

Cultural stigma, stemming from a lack of understanding of mental health conditions and misleading media claims, can cause individuals to delay seeking treatment and lead to marginalization and harm for individuals living with mental illness [15, 16]. There are three types of stigmas: public stigma, self-stigma, and institutional stigma. Public stigma is negative and discriminatory beliefs by others, whereas self-stigma is negative beliefs about mental illness that an individual may believe to be true about themselves [15, 17]. Institutional stigma involves systematic governmental or other organizational policies that either intentionally or unintentionally limit the opportunities for those living with mental illness.

Researchers believe stigma still creates a barrier to mental health help-seeking behaviors amongst Black women. For example, Simmons found that Black women often do not seek mental health services out of fear that they would be stigmatized, expressing that they did not want to be seen as “damaged” for seeking those services [18]. Likewise, Nelson and colleagues found that although Black women believed they should seek treatment for depression, they still rejected the thought of actually using mental health services [17].

Literature suggests that Blacks hold negative perceptions of mental health treatment and service utilization regardless of their psychological diagnosis [15, 19]. Specifically, when speaking about their experiences with depression, Black women, ages 30-45, have reported minimizing their experiences and believing that having those symptoms is an inevitable part of the Black woman experience [20].

1.3 Psychological Implications of the “Strong” Black Woman

The Strong Black Woman paradigm (also referred to as the Superwoman Schema) provides a unique theoretical perspective that broadens our understanding of Black women’s lives and how they relate to the world [18]. The Strong Black Woman (SBW) paradigm, as described by [21], is a schema that prescribes culturally specific feminine expectations for Black women. These expectations include self-sacrificing, caring for others, resilience, putting others’ needs before their own, and appearing to show unwavering strength [22, 23].

Perceptions of the Strong Black Woman are also attributed as motherly because she provides emotional, spiritual, or financial support to others [22, 23]. Similarly, research suggests that internalizing these expectations are a direct response to racism and sexism [24]. Unfortunately, internalizing the role of the SBW has its consequences on Black women’s wellbeing, often leaving them depleted physically, emotionally, and mentally [5, 25].

Woods-Giscombe (2010) found that the Black women in their focus groups perceived the Superwoman role as pertinent in preserving different facets of their lived experiences: preserving their self for survival in the workforce, romantic relationships, and society at large; preserving the Black community by way of philanthropy to address the needs of the Black community; and preserving their families, particularly supporting their children and parents [26]. Although the SBW ideal is entrenched in strength and preservation, and Black women have internalized those characteristics to protect themselves, these ideals are linked to adverse health outcomes for Black women.

Over the past several decades, research has found that Black women’s experiences with discrimination increase their chances of developing depressive symptoms [17, 27-29]. For example, Black women experiencing racial discrimination are less psychologically resilient and more prone to depression. Women who were subjected to higher levels of unfair treatment experienced more depressive symptoms, in part because day-to-day discrimination undermined their overall confidence in their ability to manage life challenges, leaving them feeling powerless and depressed [30]. In addition, women of color are more likely to experience microaggressions, or personal slights, insults, and invalidations that are potentially less intense but more frequent than more overt/direct forms of racial discrimination [31].

Women have reported coping with stress by emotional eating, smoking, dysfunctional sleep patterns (e.g., regularly staying up late to finish tasks), and postponement of self-care [26]. Mainly concerning Black women’s psychological health, embodying the SBW ideal has led them to deemphasize their feelings, wants, and desires to accommodate the needs of others while also reducing their ability to express genuine fear, hurt, and inadequacies [25]. Black women have also reported sadness, hopelessness, and symptoms of depression [24].

Black women who are more accepting of the SBW archetype are at a greater risk for depression [5, 23]. For example, Donovan & West [23] examined the endorsement of SBW and the relationship between stress and mental health among Black women. Their findings showed that SBW moderated the relationship between anxiety and depressive symptoms; moderate and high levels of SBW endorsement increased the positive relationship between stress and depressive symptoms. Further, the SBW endorsement was associated with lower self-esteem and increased hostility and sensitivity [16]. The SBW schema has also led to harmful psychological outcomes [32]. Harrington and colleagues [32] investigated the association between binge eating and exposure to trauma and

distress [17, 27-29]. Their findings show that trauma exposure/distress influences the likelihood of the SBW ideology being internalized, affecting binge eating through its effects on emotion regulation and eating for psychological reasons. Their results suggest that the SBW ideology manifests in Black women via emotion regulation difficulties and using eating to fulfill psychological needs [32].

Black women's experiences with discrimination also pose significant problems in their lives. Case in point, Black women's experiences with discrimination have increased their chances of developing depressive symptoms [17, 27-29]. Additionally, Black women experiencing racial discrimination are less psychologically resilient and more prone to depression. Women who were subjected to higher levels of unfair treatment experienced more depressive symptoms, in part because day-to-day discrimination undermined their overall confidence in their ability to manage life challenges, leaving them feeling powerless and depressed [30]. In addition, Black American women are more likely to experience microaggressions, or personal slights, insults, and invalidations that are potentially less intense but more frequent than more overt/direct forms of racial discrimination [31]. These race and gender-based stressors can be further exaggerated by labor wage disparities, role strain, and other health problems associated with the onset of mental illness [14, 31]. For example, Carter and colleagues suggest that Black American women are at an increased risk of developing high blood pressure, diabetes, and other chronic illnesses due to race and gender-related stressors [33].

Previous research has examined the perceptions and lived experiences of various groups diagnosed with depression. However, there is a lack of research specifically focused on clinically depressed Black women. We defined clinical depression as someone who has been diagnosed with depression by a licensed mental health provider at any point in their life. The interview questions guiding this study and analysis were: (1) Do you believe that your depression diagnosis has led to differential treatment? (2) If so, what are the reasons for this perceived differential treatment?

2. Materials and Methods

A qualitative research design using an open-ended questionnaire was performed. This research design was selected because open-ended questions allow respondents to express their opinions without being influenced by the researcher. Furthermore, one of the advantages of using open-ended questions is the possibility of discovering the responses that individuals give spontaneously, thus, avoiding the bias that may result from suggesting responses to individuals, a bias that may occur in the case of close-ended questions [34]. In addition, some researchers believe that having participants respond freely to questions allows the question to better measure their salient concerns, rather than the closed-ended format that forces people to choose among a fixed set of responses [35].

2.1 Participants

A convenience sample of Black women (N = 28) clinically diagnosed with depression in the United States were recruited for participation via Qualtrics. Participants were eligible if they self-identified as Black, biracial, or Caribbean Black, were 18 years of age or older, were diagnosed with clinical depression, and residing in the United States.

The eligibility criteria were established based on previous literature suggesting that Blacks are reluctant to treatment or adhere to conventional therapy because of financial and racial barriers

and may be influenced by their beliefs about the causes of mental illness [36]. Additionally, researchers decided to select Caribbean Black and biracial individuals because previous studies of Black mental health have not addressed the mental health consequences of within-group ethnic variation [37]. Further, participants were required to be at least 18 years of age or older and were selected based on the recruitment process [37].

2.2 Procedure

Research approval was obtained from the Institutional Review Board at the authors' university. Participants interested in participating in the study were sent an email invitation or prompted to the respective online survey platform, Qualtrics, which validated participants' names, addresses, and dates of birth. Qualtrics was selected because participants can be recruited from various locations. Additionally, Qualtrics is beneficial because online survey platforms allow for more efficient research due to auto-generated data files, streamlined data management, and direct replication [38].

Before beginning the open-ended questionnaire, participants were asked screening questions to ensure they self-identified as Black, biracial, or Caribbean Black, were 18 years of age or older, and were diagnosed with clinical depression. Once the eligibility criteria were established, participants were provided with general information regarding the open-ended questionnaire and prompted to complete an informed consent form. Participants were allowed the opportunity to discontinue the open-ended questionnaire at any time. At the end of the open-ended questionnaire, participants were provided a direct link to the National Alliance on Mental Illness should they need assistance.

Participants were recruited via Qualtrics from July 2019 until November 2019. Qualtrics, an online market research sample aggregator [38, 39], recruited participants from various sources, including targeted email lists, gaming sites, website intercept recruitment, customer loyalty web portals, social media, and permission-based networks. All participants provided informed consent before completing the anonymous qualitative survey. Participation was voluntary, and consent was documented prior to data collection.

2.2.1 Measurements

An open-ended questionnaire based on Black women's experiences living with clinical depression was designed. Eighteen demographic questions were also used to assess sexuality, age, state of residence, relationship status, the highest level of education completed, annual household income, employment status, religion, length of depression diagnosis, who diagnosed the depression, primary treatment provider for the depression, race of medical or mental health treatment provider, preference of race of treatment provider, and type of insurance.

2.3 Data Analysis

The research team comprises three Black women and one white, gender-nonconforming individual with over 20 years of research experience. Experiences as Black women and as a white gender nonconforming individual have shaped our research interests, focusing on Black women's experiences living at the intersection of multiple marginalized identities. It should be noted that the first and second authors have previously conducted qualitative research using thematic analysis.

A thematic analysis, a multi-step process, was employed during data collection and analysis [39, 40]. Thematic analysis was used to identify commonalities, concepts, and new ideas within the data [41]. Before starting coding, each researcher read the open-ended questionnaires repeatedly to immerse themselves in the open-ended questionnaires and familiarize themselves with the data [42].

After reading the interviews repeatedly, the authors created codebooks to conduct open-ended coding. Line-by-line coding then occurred to enhance the validity of the findings. Next, the authors discussed each code until an agreement was met. The data were then categorized and cataloged into a master codebook that represented all survey data. The research team then conducted axial coding, identifying recurring themes and specific quotes. Lastly, the team reviewed all coding to ensure the credibility of the findings.

3. Results

3.1 Demographic Data

Table 1 presents the demographic characteristics that were collected for this study. Included in the characteristics are 28 self-identified Black women who were 18-73 years of age that reported a diagnosis of clinical depression and were currently receiving or have received treatment for in the past. The majority of the participants utilized Medicaid, Medicare, or governmental insurance (n = 26), were single (n = 16), received a high school diploma or graduation equivalency (n = 16), and were employed (n = 13). When asked how long ago they were diagnosed, 13 participants responded that they had been diagnosed more than five years before participating in the study.

Table 1 Participant Demographic Characteristics.

Characteristics	(n = 28)
Type of Insurance Held	
Medicaid/Medicare/Governmental Insurance	26
None/Personal income (cash, check, or credit card)	2
Marital Status	
Divorced	1
Legally separated	2
Married	6
Single	16
Single but living with partner	2
Widowed	1
Educational Level	
Associate Degree	5
Bachelor's Degree	4
Doctoral/Professional Degree	1
Graduated High School/GED	16
Master's Degree	2
Annual Household Income	
Less than \$10,000	1
\$10,000 to less than \$15,000	4
\$15,000 to less than \$20,000	1
\$20,000 to less than \$25,000	1
\$25,000 to less than \$35,000	6
\$35,000 to less than \$50,000	5
\$50,000 to less than \$75,000	6
\$75,000 or more	4
Employment Status	
Employed	13
Homemaker	1
Out of work for 1 year or more	1
Retired	2
Self-employed	7
Unable to work	4
Time Since Depression Diagnosis	
1-2 years ago	6
3-5 years ago	7
More than five years ago	13
Within the last year	2

3.2 Qualitative Results

All collected materials were organized into three themes identified through thematic analysis. Participants in this study reported experiences related to their depression, specifically: (1) the legacy of scientific racism, (2) discriminatory profiling and under-diagnosis within healthcare settings, and (3) stigma encountered at the intersection of community and care.

3.2.1 The Legacy of Scientific Racism

Fifty-seven percent ($n = 16/28$) of the participants reflected on the longstanding racial divide in how providers have historically perceived and treated clinical depression among Black and White individuals. Black women in this study often described witnessing or experiencing disparities rooted in the historical Black-White treatment divide, particularly in healthcare settings. Participants noted that Blacks have historically been subjected to harsher, more punitive responses to mental health, while White patients have been met with more empathy. A 27-year-old participant stated, *"I feel being Black, growing up, it was a difference in the way Whites and Blacks handled the depression situation differently and it would be the Whites [that would] kill themselves and the Blacks would be put somewhere locked up until they could handle being with the world again."* Specifically, in terms of experiences with healthcare professionals, a 45-year-old participant stated, *"My experience most medical doctors really don't take Black Americans seriously they stereotype before they treat, they treat with misconceptions of who we are."* Such accounts illuminate how racial stereotypes and medical bias remain entrenched in healthcare, reinforcing unequal healthcare treatment.

3.2.2 Profiling and Underdiagnosis in Healthcare Settings

Twenty-one percent ($n = 6/28$) of the participants reported experiencing racial bias in mental health care or in health care settings, through discriminatory profiling and underdiagnosis. Several participants reported feeling that they were treated differently or profiled when seeking help for their mental health. For instance, a 31-year-old participant stated, *"Treated differently. White are more cared for... Blacks [are] dismissed more on it"* this quote suggests that Black women perceive racial disparity in treatment and how depression is addressed. Others pointed to more systemic forms of racial profiling. For example, a 49-year-old participant stated, *"...they usually profile Blacks more strenuously than Whites. I have experienced this personally."* A 26-year-old participant noted, *"I think that when it comes to being African-American, White doctors don't believe us that we are suffering from it like they do with White patients. I feel like they don't ask White patients questions that they ask us and they don't second-guess White patients like they do us. I also feel like they don't take us as serious as they do their White patients and they don't go the extra mile like they do with their white patients."* Additionally, participants expressed concerns about Black women being underdiagnosed in the diagnostic process. A 55-year-old participant stated, *"Blacks under diagnosed with the condition."* These accounts reflect how discriminatory profiling and lack of diagnosis created systemic inequities and contribute to the marginalization of Black women with depression.

3.2.3 Stigma at the Crossroads of Community and Care

Twenty-one percent ($n = 6/28$) of the participants described encountering stigma that led to profound feelings of emotional invalidation. This often manifested as being teased, mocked, or

having their emotions dismissed, particularly when attempting to discuss their depression. Several participants noted simultaneously experiencing stigma regarding their depression from multiple sources, particularly in spaces where one might expect to feel “safe”. Their accounts call attention to the multifaceted nature of the stigma that Black women encounter both within the Black community and in healthcare settings.

One participant shared that she did not believe that her provider took her mental health concerns seriously. A 24-year-old participant shared, *“I think as a Black person, when I tell someone that I’m depressed, the first thing that will happen is me being teased, or accused of seeking attention, or even accused of dealing with ‘White people stuff’”. For doctors it’s not common place either, I guess, in reality lots of us are depressed, lots of women are really depressed too. It’s hard being Black and a woman, because I know that no matter what I do I’ll never ever be up to anyone’s standard. I’ll be mocked--- and the person never means to hurt me, but that’s just what seems to happen. Dating fails for me, work fails for me, hell having dreads makes me trash too. It’s hard, and when you try getting professional help, even they treat you like you’re lying is so disheartening.”* A 29-year-old participant similarly stated, *“I feel like in the Black community, we make depression and other mental illnesses a joke or just don’t think it exists we don’t talk about it much Whites are freely with it and more open to understanding.”* Additionally, other participants echoed the sentiment that Black individuals, specifically Black women, face the unique burden of stigma and are expected to exhibit strength through emotional distress. A 20-year-old participant stated, *“Whites had more support, Blacks have to be tough.”* Collectively, these narratives underscore the compounded stigma Black women face, not only with cultural norms but also with systemic invalidation in healthcare settings, highlighting a barrier to equitable healthcare.

4. Discussion

The present study sought to gain a better understanding of Black women’s experiences living with clinical depression. Findings suggest that racism impacts Black women’s lived experiences with clinical depression in the form of (1) the legacy of scientific racism, (2) discriminatory profiling and underdiagnosis due to race in healthcare settings, and (3) Stigma at the Crossroads of Community and Care. Results from this study are consistent with previous studies, adding additional insight directly from Black women diagnosed with depression.

Based on the participants’ responses in this study, fifty-seven percent reported experiencing racism while seeking healthcare services. More than half of the participants focused on the issues, concerns, or problems they had in healthcare settings and with healthcare professionals. This is consistent with the findings from [43], who showed that depression care inequities experienced by Black women were less likely to receive appropriate screening, diagnosis, referral, or treatment (including medication or psychotherapy). Kemet et al. found that Black women expressed a desire for comprehensive, accessible, and race-conscious behavioral health services and a need for providers to have an understanding of structural racism and white supremacy [44].

According to the participants in this study, twenty-one percent stated they experienced discriminatory profiling and underdiagnosis due to race in healthcare settings, while seeking mental health care services. This is consistent with previous findings linking help-seeking behaviors with experiences seeking professional psychological health services. Sonik et al. found that over one-third of Blacks with depression reported discrimination from a healthcare provider, and over one-

quarter reported experiencing discrimination from both the provider and front desk staff [45]. Sonik and colleagues also found that Blacks who reported incidences of past healthcare discrimination were more likely to prefer medication and less likely to choose talk therapy [45]. In contrast, some Black women have had more positive experiences with healthcare services. For example, the Nelson et al. study found two-thirds of the Black women participants reported personal positive experiences with therapy and often view treatment for mental health as a form of self-care [17].

Lastly, when assessing stigma, twenty-one percent of the participants reported experiencing negative encounters related to stigma. Several participants described mental health concerns in the Black community and the lack of conversations about conditions and treatment due to the fear of being judged or ridiculed. This is consistent with the study from [46], where their findings suggest a link between stigma concerns and psychological distress. On the contrary, there are Black women who believe there is an expectation to rely on their familial connections and religious resources for treatment without even considering counseling as an option [47].

4.1 Limitations

Several limitations to this study are worth noting, the first being social desirability bias. Social desirability bias involves presenting oneself and one's social context in a way that is perceived as socially acceptable but not wholly reflective of one's reality [48]. This bias represents itself in research as a contrast in a participant's perception of their reality and the demonstration of that reality to researchers [48]. Participants in this study may have self-reported responses that differ from their actual attitudes and behaviors; as such, we did not control for social desirability in our study. A second limitation is that we used a convenience sampling method for recruiting participants, which can be explained as a sampling strategy where participants are selected based explicitly on their accessibility and/or proximity to the research [49]. A fundamental disadvantage of convenience sampling is that results cannot be generalized because the sample poorly represents the target population [49]. Next, the surveyed population of Black women self-reported that they have been clinically diagnosed with depression. While we have no way of verifying the accuracy of this information, we take the participants' words in good faith. Lastly, we acknowledge the study's limitations around the use of open-ended survey questions. Open-ended survey questions take more time and effort to answer, potentially resulting in fatigue, superficial answers, and reduced completion rates. These challenges may be particularly pronounced for individuals with lower literacy levels, certain disabilities, or those completing surveys on mobile devices, thereby increasing the likelihood of missing responses and participant attrition [50].

4.2 Practice Implications

There is a growing body of literature that warns social scientists that changes need to be made to address health disparities and barriers related to mental healthcare in the Black community. Research in this area offers evidence-based recommendations on how to proceed. First, there is a need to train culturally competent clinicians [51, 52]. While other studies show that a counselor of the same race may impact treatment outcomes in a positive manner [13, 53]; other studies show that this may have little to no impact on the quality or outcomes of care for Black patients. Instead, providers should recognize the importance of acknowledging and discussing race regardless of the providers racial background [51, 54-57] However, many providers fear discussing race even after

cultural competence training [51]. Providers report this discomfort in discussions with patients and colleagues, especially when a racial issue needs to be addressed within the workplace [51, 58].

Second, evidence-based recommendations encourage providers to reflect to better understand their own cultural biases [51, 58]. These findings are critical in considering current beliefs and concerns regarding treating conditions within the Black community. Long-standing reparative research suggests treatment success is often dependent on the client's perceived positive relationship with the provider and perceived positive experiences in treatment. However, it should be noted that few studies focus on the patient's perceived treatment experiences, and even fewer studies have been conducted related to patients' perceptions of the mental health treatment experience or relationship with the provider related to race [59, 60].

4.3 Future Research

Limited research has explored the experiences of Black women with depression, especially how their racial identity has impacted their interactions with health professionals. In addition, Black women are often not considered in conversations related to experiences with mental health diagnoses. This paucity of research can contribute to the undertreatment of depression for Black women. Black women generally under-utilize mental health services for various reasons; thus, our study was able to demonstrate how adverse racial experiences with health care professionals can impact the use of those services. Further research is needed to examine Black women's experiences with their treatment plan. As research continues to address this disparity in help-seeking behaviors, it is imperative to center the voices of Black women in research surrounding experiences with mental health diagnoses. These discussions underscore the critical need for culturally sensitive approaches in mental health treatment, a need that our study highlights and which we further reflect on in our concluding remarks.

5. Conclusions

From our work, we have been able to justify needed improvements to the structural systems in place that regularly affect the experiences of Black women. Despite being reported to possess similar rates of depression as White women, evidence was provided that Black women are still going through tremendous disparities in the diagnosis and treatment of depression. The literature review highlights that the mistrust of the healthcare practice and stigma surrounding mental health ailments can lead to delays in mental health interventions among Black women.

Author Contributions

Kamesha Spates and Na'Tasha Evans conceptualized the study, designed the survey, developed the methodology, oversaw analysis, wrote the introduction and conclusion, revised the manuscript, and supervised the project. Siobhán Hicks and Bethanie Mauerman drafted the literature review, methods, and findings sections under the supervision of the last author. All authors approved the final version of the manuscript.

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Competing Interests

The authors declare no conflicts of interest.

Data Availability Statement

The data supporting the findings of this study are not publicly available due to privacy and ethical considerations. However, the corresponding author will provide access to the data upon reasonable request.

AI-Assisted Technologies Statement

During the preparation of this manuscript, the authors used Grammarly and Microsoft Copilot for the purposes of revising the manuscript for grammatical clarity and correctness. The authors have reviewed and edited all output and take full responsibility for the content of this publication.

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