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Mental Health Care Treatment Seeking among African Americans and Caribbean Blacks: What is the role of Religiosity/Spirituality?

Natalie Turner, BSW¹, Julia Hastings, MSW, Ph.D.^{1,2}, and Harold W. Neighbors, Ph.D.³

¹School of Social Welfare, University at Albany, State University of New York, Albany, NY, USA

²School of Public Health, University at Albany, State University of New York, Albany, NY, USA

³Division of Public Health, Department of Family Medicine, College of Human Medicine, Michigan State University, Flint, Michigan

Abstract

Objectives: As adults increase in age, the likelihood for using mental health care services decrease. Further, the literature suggests that racial/ethnic minorities, such as African American and Caribbean Blacks, are less likely to use mental health care services, in general and more specifically as age increases. Underutilization of mental health services by older adults can result in a decrease in quality of life, and significant costs to families, employers, and health systems. As such, this underutilization appears to be a social problem that requires research attention.

Methods: The study explored the differences in relationships between mental health care usage and strength of religious/spiritual beliefs between African American and Caribbean Black older adults (54 years or older) and adults (18–53 years) living in the US using data from the National Survey of American Life (NSAL). Descriptive statistics and logistic regression analyses were conducted using Stata version 13.1.

Results: Subjective ratings about the strength of religious/spiritual beliefs (OR = 1.26; 95 CI: 0.99, 1.61), age (OR = 0.62; 95 CI: 0.48, 0.81), and sex (OR = 1.59; 95 CI: 1.25, 2.02) were significantly associated with the odds of seeking mental health care. Additionally, the results show that those living in the South were less likely to seek mental health care services (OR = 0.47; 95 CI: 0.37, 0.60).

Conclusion: Strong religious/spiritual beliefs may promote mental health care usage. Future studies should examine the strength of religious/spiritual beliefs on mental health care usage among different demographic groups.

Keywords

aging; mental health services; NSAL; religion; spirituality

Correspondence should be directed to Julia F. Hastings at, jhastings2@albany.edu, Postal address: 135 Western Ave, Albany, NY 12222, Telephone: (518) 591-8751.

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Introduction

Statement of Problem

The literature on older adults with mental health diagnoses have shown many reasons for the underutilization of mental health services, including a lack of knowledge about the availability of sources, lack of transportation to services, and minimal financial support for services. Older adults feeling as though they can take care of mental health problems on their own or feeling that the concern will go away with time (Sorkin, Murphy, Nguyen, & Biegler, 2016) becomes a major gap that mental health agencies, professionals, and affected community members have not been able to eliminate with consistency. In one study, 65.9% of the older participants with major depressive disorder and 72.5% with anxiety were not receiving mental health care (Garrido, Kane, Kaas, Kane, 2011). The research also indicates that older adults report being concerned about the stigma associated with seeking mental health care (Garrido et al., 2011; Jimenez, Bartels, Cardenas, and Alegria, 2013). As such, while US adults and the growing number of older adults show similar levels of mental health concerns, older adults are less likely to receive care.

The percentage of racial/ethnic minority older adults has increased from 18% in 2004, to 22% in 2015, and is expected to continue to rise over the next fifteen years (Administration on Aging, 2016). Racial and ethnic minorities tend to use mental health care services less than whites (McGuire and Miranda, 2008). Specifically, African Americans and Caribbean Blacks use these services at significantly lower rates compared to non-Hispanic Whites (Jackson et al., 2007). It is important to pay attention to older adults because as the percentage of racial/ethnic minority older adults increases, the provision of mental health services will have to become more culturally responsive to better serve this population group (Administration on Aging, 2016). Research has consistently shown that strength of religious beliefs increases with age (Bengston, Putney, Silverstein, and Harris, 2015). Studies have also indicated that more frequent participation in religious/spiritual activities is associated with a lower likelihood of experiencing depression or emotional distress (Meisenhelder and Chandler, 2002; Hongtu, Cheal, McDonel, Herr, Zubritsky, & Levkoff, 2007; Taylor, Chatters, and Abelson, 2012).

Examining the mental health care service use and religion literature shows conflicting findings. Studies have reported inconsistently on whether strength of religious beliefs and religious affiliation are associated with mental health care seeking behavior. Hongtu et al. (2007) and Pickard (2006) have both shown no correlation between religious attendance and utilization of mental health services, while Pickard (2006) reported a correlation between religiosity and the use of these services. However, neither focused on the correlation between strength of religious/spiritual beliefs and the use of mental health services among older adults from different racial/ethnic groups, African American and Caribbean Black.

Theoretical Framework

Based on the person-in-environment theory, an individual's behavior should be examined in the context of his or her environment. The environment can directly impact the way that a person acts and vice versa. A person's environment is connected by religious, historical,

physical, and social environments (Kondrat, 2013). For this study, strength of religiosity/spirituality was explored to understand the impact this may have on an individual's mental health care usage. Historical environments were also focused upon via two racial and ethnic identities -- African Americans and Caribbean Blacks. Although these two groups are often combined into one category, each holds a different historical background in the United States that may impact the strength of religiosity/spirituality or mental health care usage.

Another theoretical model of health service utilization is the Andersen Behavioral Model of Health Service Use (Andersen, 2008). This model seeks to identify factors that promote the use of health services. The current model suggests that contextual and individual factors can affect the use of health services, much like the person-in-environment theory (Andersen, 2008). The Andersen Behavioral Model does not explicitly focus on the impact of religion/spirituality but does indicate that a person's belief system could influence health care seeking behavior.

A gap in the current literature exists on what impact an individual's sense of religiosity/spirituality plays in mental health service utilization, and whether this relationship differs by Black ethnicity among older groups. Andersen's theory suggests that physical and historical environments as well as other factors can influence people's actions and behaviors, such as mental health care seeking behavior.

Study Purpose

The purpose of this study was to provide insight into the relationships among ethnicity, religiosity, and the use of mental health services. The research sought to gain a better understanding of the lower use of mental health care by older African American adults compared to younger adults for two Black ethnic groups. This research also investigated whether stronger spiritual/religious beliefs were associated with a higher likelihood of using mental health services. Three research questions guided the study.

1. What is the prevalence of African Americans and Caribbean Blacks seeking mental health services?
2. Are there demographic characteristics related to strong versus less strong religious/spiritual beliefs?
3.
 - A) Is age (18–53 years and 54 years and older) related to the use of mental health care among African American and Caribbean Black adults?
 - B) What factors differentiate potential age differences in those who seek mental health care and those who do not?

Literature Review

Taylor, Chatters, and Jackson (2007) reported that African American and Caribbean Black older adults were more likely to rate themselves highly on a self-rated religiosity scale compared to younger and middle age adults. The idea that Black older adults have stronger religious/spiritual beliefs is further supported by a 2009 report that found that while 19% of African Americans under the age of 30 were unaffiliated with a religion, only 7% of African Americans over the age of 65 were unaffiliated (Pew Research Center, 2009). When looking

at African Americans across the lifespan, nearly 80% say that religion is very important to them (Pew Research Center, 2009). There is also evidence suggesting that increased religiosity/spirituality is not simply a cohort effect, but an aging one in general. Bengston, Putney, Silverstein, and Harris (2015) found that while the concepts of what constitutes religion or spirituality changed with cohorts, older adults across time were significantly more likely to consider themselves strongly religious or spiritual compared to younger adults.

Other studies have reported that religious/spiritual practices serve in a coping capacity to deal with life circumstances. Chatters, Taylor, Jackson, and Lincoln (2008) studied the differences of religious coping between African Americans, and Caribbean Blacks. Chatters et al. (2008) found that overall, African Americans and Caribbean Blacks were both likely to subscribe to the idea that prayer is important for dealing with stressful life situations, look to God for strength and identify religious resources and behaviors as important for dealing with life situations (Chatters et al., 2008). Dunn and Horgas (2000) found similar results when examining religious coping in terms of race; people who identified as Black are more likely to use prayer to cope with stress. The Dunn and Horgas (2000) study, however, did not differentiate between black ethnicities such as African American and Caribbean Black. Based on the research, the findings highlight how ethnic groups are more similar in the strength and use religious/spiritual beliefs.

In terms of mental health care seeking behavior, studies have shown that older adults are less likely to seek and receive mental health services compared to younger and middle aged adults (American Psychological Association, 2016; Neighbors et al., 2007; Husaini, Moore, and Cain, 1994). Husaini, Moore, and Cain (1994) found that both White and Black older adults were less likely to use formal mental health services and were more in favor of consulting with their clergy or the family physician for mental health concerns. Older adults (e.g. African American, Caribbean Blacks and Whites) are more likely to speak with their clergy or other non-health providers for mental health concerns (Neighbors et al., 2007; Pickard and Baorong, 2008; Taylor et al., 2011;)

Neighbors et al. (2007) used National Survey of American Life (NSAL) data to examine the differences between non-Hispanic Whites, African Americans, and Caribbean Blacks in terms of mental health service use (Alegria, Margarita, Jackson, Kessler, & Takeuchi, 2007). Neighbors et al. (2007) found that more non-Hispanic Whites use mental health services than African Americans and Caribbean Blacks, with older African Americans using services the least. In addition, African American women were more likely to use these services than African American men, while there was no sex difference in Caribbean Blacks.

Prior studies have also reported on the differences in religious/spiritual practices between the different racial and ethnic groups. Chatters, Taylor, Jackson, and Lincoln (2008) studied the differences of religious coping between non-Hispanic Whites, African Americans, and Caribbean Blacks. Chatters et al. (2008) found that overall, African Americans and Caribbean Blacks were more likely to subscribe to the idea that prayer is important for dealing with stressful life situations. Similarly, African Americans and Caribbean Blacks looked to God for strength and were more likely than non-Hispanic Whites to identify

religious resources and behaviors as important for dealing with life situations (Chatters et al., 2008). Dunn and Horgas (2000) found similar results when examining religious coping in terms of race, with people who identified as Black more likely to use prayer to cope with stress. This study, however, did not differentiate between different black ethnicities such as African American and Caribbean Black.

Women have been found to be more likely than men to report on the importance of prayer for coping, and are more likely to report turning to God for strength (Chatters et al., 2008; Dunn and Horgas, 2000; Garrido, et al., 2011). Women are also more likely to use mental health care services than men (Pattyn, Verhaeghe, and Bracke, 2015). Regarding geographic location, people in the South were more likely than those in the North to report on the importance of prayer for coping and more likely to report turning to God for strength (Chatters et al., 2008; Taylor, Chatters, and Jackson, 2007).

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

Methods

Data from the National Survey of American Life (NSAL) was analyzed to assess the strength of religious/spiritual beliefs on mental health care seeking behavior among African Americans and Caribbean Blacks.

Sample

The NSAL was a national household probability sample consisting of 6,082 face-to-face interviews with English-speaking persons 18 years or older, including 3,570 African Americans, 1,621 Blacks of Caribbean descent, and 891 non-Hispanic Whites (Jackson et al., 2004). Face-to-face interviews were conducted throughout the United States in both rural and urban areas to proportionally represent African Americans in the way they are distributed nationally. The Caribbean Black sample was selected from similar areas, and from an area probability sampling frame consisting of segments where Caribbean Blacks made up more than 10% of the population. The overall response rate was 72.3%. Response rates for each of the subgroups were 70.7% for African Americans, 77.7% for Caribbean

Blacks, and 69.7% for non-Hispanic Whites. Data collection occurred from February 2001 to June 2003.

The study sample was divided by age where old age was defined as persons who were 54 years of age or older and young age represented respondents below 54 years. The age cutoffs are especially important to understand conditions specific to older Blacks as there is little research and concrete information on mental health care seeking behavior. The age cutoffs are based on prior research on religious correlates of the mental health of older African Americans where 55 years and older was defined as an important life indicator due to earlier mortality (see for example, Chatters, Bullard, Taylor, Woodward, Neighbors, & Jackson, 2008; Blazer, 2007; Taylor, Chatters, and Levin, 2004). The literature shows that although African Americans have made significant gains in life expectancy, and the mortality gap between White and Black Americans has been cut in half since 1999, life expectancies remain lower for African American men (72.3 years) and women (78.5 years) compared to White men (76.7 years) and women (81.5 years) (USA Life Expectancy, 2016).

Measures

Demographics — Respondents who reported being 54 years or older were categorized as older adults and respondents who reported being 18 to 53 years were defined as adults to acknowledge the lower life expectancy figures associated with African Americans. African American and Caribbean Black respondents had to self-identify his or her race. Gender was measured through self-report where respondents were either male or female. Region was assessed through self-report and individuals were either from the Northeast, Midwest, South or West.

Dependent Variable — Mental health care seeking served as the dependent variable. Respondents were asked “Did you ever in your life have a session of psychological counseling or therapy that lasted 30 minutes or longer with any type of professional?” Responses were dichotomously coded as “yes” to have used mental health services or “no”. Non-Hispanic Whites were not included in the study because the dependent variable question was not asked of this group.

Main Independent Variable — Two questions asked about strength of religious and or spiritual beliefs. The questions were, a) “How religious would you say you are?” with response options as 1) very religious, 2) fairly religious, 3) not too religious, or 4) not religious at all. The second questions asked, “How spiritual would you say you are?” Response categories included, a) very spiritual, b) fairly spiritual, c) not too spiritual, and d) not spiritual at all. The variables were combined to gain a comprehensive understanding of religiosity and spirituality. A new set of response categories was created which combined responses to both “very religious and very spiritual” as meaning strongly religious or spiritual. The other response categories were: “fairly religious, not too religious, not religious at all, fairly spiritual, not too spiritual, and not spiritual at all” and were combined to “not very religious and not very spiritual.”

Analysis Strategy

The analysis for the study occurred in three steps. First, simple descriptive statistics were used to characterize the sample. Second, bivariate analyses were conducted. Chi-Square tests assessed whether the correlation between mental health service utilization and strength of religious/spiritual beliefs was significant. Other Chi-Square analyses tested associations between the strength of religious/spiritual beliefs and the demographic variables. Third, logistic regression analyses were performed on the main model to examine the relationship between religious/spiritual beliefs and mental health care service utilization. Odds ratios in the logistic regressions adjusted for demographic variables.

All analyses were completed with the available probability weights using the SVY commands in STATA Version 13.1 software, which handles the NSAL's complex survey design (Heeringa et al., 2004). The survey weights adjust for differential probabilities of selection and nonresponse to represent the Black population. Differences were considered significant at 0.05 and 95% confidence intervals (CI) were presented.

Results

The analytic sample consisted of 5,008 persons where 93.91% participants self-identified as African Americans and 6.1% self-identified as Caribbean Blacks. Respondents ranged in age from 18 to 98 years ($M = 43.22$ and $SE = 0.21$). Slightly over half (55.6%) of the respondents were women and almost half (54.7%) reside in the South (see Table 1). Outside of residing in the South, respondents lived in near equal percentages throughout the US, Northeast (18.2%), Midwest (17.9%), and West (9.2%). On average, a lower prevalence of older recipients reported holding strong religious/spiritual beliefs (14.6%) than younger adults (33.5%). In total, 660 (15.23%) African Americans and Caribbean Blacks of all ages attended a counseling session lasting longer than 30 minutes at any point in their lives. Persons who were 54 years or older attended fewer counseling sessions than those between 18 and 54 years, supporting prior research findings (Jackson et al., 2007; Neighbors et al., 2007).

Bivariate Analysis: Strength of religious/spiritual beliefs by region

Table 2 presents the association between region and strength of religious/spiritual beliefs among African Americans and Caribbean Blacks. The prevalence of the strongest religious/spiritual beliefs ratings was higher among those respondents who lived in the South (54.7%) than those who lived in the North (18.15%), Midwest (18.0%), or the West (9.15%). In general, the prevalence difference between strong and weak religious beliefs was 3%.

Logistic regression analysis: Mental health care seeking behavior on Strength of religious/spiritual beliefs

Table 3 presents the weighted multivariate logistic regression analyses for the relationship between mental health care seeking behavior, the strength of religious/spiritual beliefs, age, sex, and region. Subjective ratings about the strength of religious/spiritual beliefs ($OR = 1.26$; 95 CI: 0.99, 1.61), age ($OR = 0.62$; 95 CI: 0.48, 0.81), and sex ($OR = 1.59$; 95 CI: 1.25, 2.02) were significantly associated with the odds of seeking mental health care.

Additionally, the results show that those living in the South were less likely to seek mental health care services (OR = 0.47; 95 CI: 0.37, 0.60).

Discussion

The present analysis examined mental health care seeking behavior to assess the strength of religious/spiritual beliefs among a sample of Black adults. This analysis controlled for one indicator affecting mental health care seeking and three potential confounders. The statistical analysis showed that African Americans and Caribbean Blacks who have stronger religious/spiritual beliefs were more likely to seek mental health care. The finding is supported by Pickard's (2006) research study. Subjective ratings of the strength of religious/spiritual beliefs were significantly associated with the odds of mental health care seeking behavior (unadjusted for other religious factors). When statistically weighted and adjusted for confounders, mental health care seeking behavior on the strength or religious/spiritual beliefs relationship remained significant, but at the .10 level. Overall, the significant relationship between strength of religious/spiritual belief ratings and the dependent variable were in the expected direction.

When all of the control variables were included together in the logistic regression model, the relationship between mental health seeking behavior and strength of religious/spiritual beliefs remained significant but not at the expected .05 level. This is likely due the magnitude of the odds ratio that proved significant at the .05 level without control variables. When control variables were added, relationship between the variables slightly decreased, indicating collinearity. The weighted logistic regression showed that younger and middle age adults were more likely to seek mental health care than older adults, which supports Neighbors et al. (2007) findings. And, women were more likely to seek mental health care than men, supporting Pattyn, Verhaeghe, and Bracke (2015).

The findings add to the discussion on mental health service underutilization by older African American and Caribbean Black adults in that it appears that admitting to needing assistance outside of individual resources is stigmatized. The underutilization of mental health services by older Black Americans has been consistently shown in the literature (Akincigil et al., 2012; Ault-Brutus and Alegria, 2016; Cook, McGuire, Lock, and Zaslavsky, 2010; Freiman and Cunningham, 1997; Hu, Snowden, Jerrell, and Nguyen, 1991; Jackson et al., 2007; Jimenez, Cook, Bartels, and Alegria, 2013; McGuire and Miranda, 2008; Neighbors et al., 2007). Underutilization of mental health services for older adults may mean that significant portions of the population are left untreated, decreasing quality of life if strength of religious/spiritual beliefs are not taken into account. Additionally, underutilizing mental health services can have negative economic consequences. Mental illness is among the top causes of disability in the US and can result in significant costs to families, employers, and health systems (SAMSHA, 2016).

To effectively combat underutilization of mental health services while considering the importance of religion/spirituality for African Americans and Caribbean Blacks, mental health professionals may want to consider forming partnerships with Black churches. While an older study done by Neighbors, Musick, and Williams (1998) found that African

Americans who went to clergy for personal problems were less likely to seek help from a mental health professional after, a more recent study done by Taylor et al. (2011) found that Caribbean Blacks were more likely to seek a mental health referral after speaking to clergy. Additionally, Dempsey, Butler, and Gaither (2016) cite numerous collaborations between the Black church and mental health professionals that promote mental health service use among Black Americans. By building a trusting relationship with a senior pastor or church advisory board and working collaboratively to promote mental health services, church members were more receptive to using mental health services (Dempsey, Butler, and Gaither, 2016).

Mental health professionals can use the information provided by Taylor et al. (2011), Dempsey, Butler, and Gaither (2016), as well as this study to improve utilization of mental health services by older and younger African Americans and Caribbean Blacks. By recognizing strong religious/spiritual beliefs as an asset and working with Black churches to build partnerships and create relevant, culturally competent mental health programming and materials, African Americans and Caribbean Blacks may be more likely to use mental health services. Additionally, an intervention that incorporates religious/spiritual beliefs to improve mental health care use will be more likely to improve outcomes for older adults specifically, since older adults are more likely to consider themselves strongly religious/spiritual and so may be more apt to be included in an intervention that considers their religiosity/spirituality (Pew Research Center, 2009; Taylor, Chatters, and Jackson, 2007).

On an individual level, strong religious/spiritual beliefs could be used to encourage mental health care use. One idea put forth by Pickard (2006) is that those who have stronger religious/spiritual beliefs put more faith in a higher power to lead them down their path and so experience less stigma when seeking mental health care. Stigma has already been shown to be a major barrier to mental health care seeking behavior (Garrido et al., 2011; Jimenez, Bartels, Cardenas, and Alegria, 2013) and so a decrease in the amount of stigma felt could lead to increased service use. In addition, building off this idea, those who are more religious/spiritual may be more willing to accept mental health counseling when presented with the opportunity due to increased faith in a higher power to lead them down their correct path. Future research may need to be done on the specific aspects of religious/spiritual beliefs that promote the use of mental health services. Such research could provide practitioners with a clearer direction on how to use religious/spiritual beliefs to improve mental health care use.

One particularly interesting finding from this study concerns region and strength of religious/spiritual beliefs. The south has usually been referred to as the “Bible Belt” due to the tendency for residents to have stronger religious/spiritual beliefs (Brunn, Webster, Archer, 2011; Chatters et al., 2008; Taylor, Chatters, and Jackson, 2007). However, our findings showed no relationship between strength of religious/spiritual beliefs and region among African Americans and Caribbean Blacks. This suggests that where a person lives does not impact the strength of their religious/spiritual beliefs, contradicting prior research showing the south as an area of high religiosity/spirituality. Our findings may indicate that the southern “Bible Belt” is losing its impact on African Americans and Caribbean Blacks.

Our study originally sought to explore the strength of religious/spiritual beliefs in mental health care seeking behavior among adult and older adult African Americans and Caribbean Blacks. Specifically, our study sought to identify differences between the two age groups among the given racial/ethnic groups. This study was guided by the inconclusive literature existing on the association between religion/spirituality and mental health care seeking behavior and the fact that older adults are less likely to seek and receive mental health services. The results showed that the strength of religious and/or spiritual beliefs represented an important factor in mental health treatment seeking. It is becoming increasingly important to identify factors that could enhance an older adult's likelihood of seeking mental health services (Administration on Aging, 2016; American Psychological Association, 2016; Husaini, Moore, and Cain, 1994; Neighbors et al., 2007).

It is important to note that the research findings must be understood within the context of limitations. First, the strength of religious/spiritual beliefs was a created variable meant to measure an individual's subjective religious/spiritual beliefs. However, the created variable measures only one aspect of religiosity/spirituality, and so other important aspects of religious/spiritual involvement were not measured. Also, non-Hispanic Whites were not included in this study because they were not asked the question, "Did you ever in your life have a session of psychological counseling or therapy that lasted 30 minutes or longer with any type of professional?" This prevented us from analyzing African Americans and Caribbean Blacks against non-Hispanic Whites. Further, there is the potential for selection bias to influence the findings because of the cross-sectional design. Selection bias is a common issue in research on the impact of religious/spiritual beliefs on treatment seeking outcomes (Chatters, Bullard, Taylor, Woodward, Neighbors, & Jackson, 2008)

With respect to the limitations noted, the study makes potentially important contributions to the literature in several ways. A large body of literature documents that religious belief systems have important influences on personal theories (cause and appropriate treatment) that trigger treatment seeking (Pargament, 1997). Knowledge about the strength of religious beliefs – a cultural foundation – may help mental health professionals to gain much needed insight into how to build stronger connections with potential intervention participants as well as potentially increasing the utility of seeking help outside of family resources. Finally, in order for mental health professionals to show sensitivity to culture and practice from a position of cultural humility, incorporating the strengths of religious/spiritual beliefs might encourage trust between African Americans and Caribbean Blacks of any age. Future studies may wish to distinguish between the many forms of mental health care seeking behavior to enhance participation if there are specific types of services more likely to be used by more religious/spiritual individuals. Other directions for research include asking additional racial/ethnic groups to participate in scientific studies. Attention to important aspects of culture, such as religions/spiritual beliefs, will increasingly serve as a valuable connecting point for service provision given that the proportion of older adults will rise in the next five years. Social researchers will need to respond to the changing census of the United States to address the emerging needs of the aging population as they tend to be more religious/spiritual than younger adults.

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Table 1:

Demographic Characteristic of the Study Sample by Age (weighted)

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

Data source: NSAL, 2001 – 2003

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

Table 2:

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

Bivariate Analysis of Region on Strength of Religious/Spiritual Beliefs Among African Americans and Caribbean Blacks (n=4,972) (weighted)					
	<i>Region n (%)</i>				
<i>Strength of Religious Beliefs</i>	North	Midwest	South	West	Total
Strong Beliefs	663 (8.6)	296 (8.89)	1,347 (26.02)	128 (4.60)	2,434 (48.12)
Weak Beliefs	733 (9.55)	307 (9.11)	1,382 (28.68)	116 (4.54)	2,538 (51.88)
Total	1,396 (18.15)	603 (18.00)	2,729 (54.70)	244 (9.15)	4,972 (100)

Data source: NSAL, 2001 – 2003

Pearson's Chi Square: 1.9788; p= 0.85

Table 3:

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

Logistic Regression of Mental Health Care Seeking Behavior and Strength of Religious/Spiritual Beliefs Among African Americans and Caribbean Blacks, Controlling for Age, Sex, and Region (n= 4,773) (weighted)				
Mental Health Care Seeking Behavior	Odds Ratio	Standard Error	95% Confidence Interval	
Strength of Religious/Spiritual Beliefs	1.26 ⁺	0.15	0.99	1.61
Age	0.62 [*]	0.08	0.48	0.81
Sex	1.59 [*]	0.19	1.25	2.02
Region ⁺				
Midwest	0.89	0.17	0.60	1.31
South	0.47 [*]	0.06	0.37	0.60
West	1.06	0.19	0.74	1.51

Data source: NSAL, 2001 – 2003

* p<.05;

⁺ p<.10;

⁺ North = Reference Group