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The Reluctance of African-Americans to Engage in Therapy

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The Reluctance of African-Americans to Engage in Therapy

By

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ABSTRACT

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This thesis is presented with the intent to explore the reasoning behind why members of the African-American culture are reluctant to enter into therapy. While the numbers of African-Americans who enter therapy continue to rise there are still persistent stigmas that make therapy a taboo option for solving problems. The goal of this qualitative study is to identify (1) if there truly is reluctance in the African-American community, (2) why the African-American community is reluctant, (3) what are the stigmas regarding mental health and therapy from the perspectives of American participants, and (4) what would help break the barriers to professional help seeking. There were two themes that are important to the body of knowledge surrounding African American reluctance to enter therapy. The first is African Americans are reluctant to enter therapy and seek professional treatment because of cultural norms that have been propagated into African American thinking and the second is fear of discrimination and race is not a factor that prevents African Americans from seeking therapy.

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Chapter I

INTRODUCTION

The origin of psychology for African Americans by African Americans started with Dr. Francis Sumner, the first African American to receive a Ph.D. in psychology in 1920. Nearly one hundred years have passed since then and the number of African American psychologists, therapists, social workers and other mental health professionals has grown greatly (American Psychological Association, 2010). The need for mental health treatment for the African American population has climbed just as sharply (Cabral & Smith, 2011). While the field has risen significantly from solely Dr. Sumner there is still a need for more cultural diversity within the field. In 2009, only 2 percent of psychiatrists, 2 percent of psychologists and 4 percent of social workers in the United States are African American (National Alliance on Mental Illness, 2009). The African American population is the second largest minority population and makes up approximately 13 percent of the United States (U.S. Census Bureau, 2010).

It is common for first time clients to experience nervousness and anxiety during their first session (Cepeda-Benito & Short, 1998). Mental health in African American communities has not been thoroughly researched because many do not want to be assessed. In a study by Neighbors et. al. (2007) about the use of services for mental disorder in African Americans and Caribbean blacks they found that only 10.1% of participants had used some form of mental health services in the past year. There exists a serious problem and challenge that African Americans underuse mental health services and, therefore, their needs for mental health are not met. The popular view is that African Americans have already been subjected to enough stigmatization through

mainstream media that they refuse to open themselves up to further ridicule and also the attitude that many do not acknowledging mental health problems as medical problems. As a culture African Americans continue to be distrustful of Caucasians whom fill the majority of roles as mental health professionals (Nickerson, Helms & Terrell, 1994). Nickerson, Helms and Terrell (1994) also found that in general cultural mistrust was the most consistent and powerful predictor of help-seeking attitudes.

The goal of this qualitative study is to explore American American perspectives on (1) if there truly is reluctance in the African-American community, (2) why the African-American community is reluctant, (3) what are the stigmas regarding mental health and therapy from the perspectives of African-American participants, and (4) what would help break the barriers to professional help seeking. This is a study exploring potential mechanisms for distrust and why these processes might occur to create such barriers. With African Americans comprising a population of roughly 40 million people, therapists need to discover how to better serve this large population.

Significance

Many African Americans do not consider entering into treatment because it is not something that is openly discussed in day to day life (McGoldrick, Giordano & Garcia-Preto, 2005). The 2012 National Healthcare Disparities Report reported that between the years of 2008-2010 African American adolescents and adults were less likely to receive treatment for depression than White adults and adolescents (U.S Department of Health and Human Services, 2013). National epidemiologic estimates show that while variations exist for some disorders, the prevalence of serious mental illness in African Americans is

roughly equivalent to that of Whites (Neighbors, Musick & Williams, 1998; Turner, Lloyd & Taylor, 2006)

Surprisingly little research has been conducted that gives African Americans a chance to verbalize their opinions and potential grievances about the mental health field and what their aversions are. There are also very few studies that allow African Americans an opportunity to discuss stigmas and stereotypes in a private one on one setting with an African American practicing therapist. Research has identified several reasons for the lack of African American clients in therapy such as mistrust of white mental health counselors, racism, and the African American perception of therapy (Nickerson, Helms & Terrell, 1994; Williams & Williams-Morris, 2000; Thompson, Bazile & Akbar, 2004).

While the mental health field has taken steps to make therapy more appealing to African Americans there is still a lot of research and work to be done to discover ways to encourage African Americans to enter treatment. A 1996 survey on clinical depression by Mental Health America (MHA) identified several barriers to treatment of African Americans. Out of the people interviewed their reasons for not going to treatment was denial of a mental health problem, embarrassment/shame, did not want help, could not afford treatment or did not have insurance, were too afraid, did now know enough about treatment or their problem and felt too hopeless to seek treatment (Mental Health America, 1996). Each of these reasons for an individual to stay away from therapy will only be addressed if stigmas and stereotypes surrounding therapy are dispelled.

The African American culture is very collective in its thinking. Coon and Kemmelmeier (2001) found that on average African Americans scored higher than

European Americans on collectivism. In this study collectivism is defined as people who identify themselves as embedded in groups and relationships. The collective thinking that surrounds the African American community contributes to the stereotype that all African Americans must be similar and to stray from that mold casts someone as an outsider or an anomaly. It is essential to understand the degree to which culture impacts the decision for African Americans to attend therapy.

Chapter II

LITERATURE REVIEW

Culture is a driving force behind our decision making. Culture in this study is defined as the customs, attitudes and behavior characteristic of a particular social group. Our environment and ethnicity informs our beliefs, opinions and actions. Not only is this true for clients but also mental health professionals. Thompson, Bazile and Akbar (2004) stated that mental health professionals often struggle with how efforts addressing issues of race and culture affect attitudes and therapeutic response. Mental health professionals are not the only people who are good at reading others. Many African Americans have been placed in situations when they know their race is making someone uncomfortable. As such, it would not be difficult for an African American client to discern that their therapist is uncomfortable discussing their race which would make the client hesitant in telling their personal troubles (Solorzano, Ceja & Yosso, 2000).

Cultural and Historical Context

It is nearly impossible to understand the true depth of this problem without understanding the history between African Americans and the health field. One of the major disasters in history regarding African Americans and the health field is the Tuskegee Experiment (Green, Maisiak, Wang, Britt & Ebeling, 1997). The U.S. Government's Public Health Service began the Tuskegee Experiment in 1932 to study the natural progression of untreated syphilis. The men in the study were not told that they had syphilis and they were deliberately kept from being treated for the condition. The study did not halt until 1972 when the story received national attention in the media. The study began with 400 uneducated African American men in Macon, Alabama. By the time the

experiment was stopped only 74 were still alive. Rough estimates of the number of men who died directly from advanced syphilis lesions was at least 28 but perhaps more than 100 (Brandt, 1978), many of whom could have been saved by penicillin which became available to the general public in 1946. An apology was not issued to the families of the patients until the late 90's by President Bill Clinton. The researchers were allowed to benefit from the study and publish their results for over forty years. It is important to note the message that this has sent to African Americans. It can be viewed as a government that does not care. If it took 30 years for a simple apology of blatant misconduct, how long would it take to recognize the mistreatment of one individual?

Many older African Americans who are still alive today have not forgotten the treatment they received from the medical and mental health field during the segregation era. In an interview with a nurse's aide at Ellen Fitzgerald Hospital, Mabel Williams (Oral History Interview, 1999) recalls that African Americans were treated in the basement and newborn infants were placed in a utility room where nurses emptied bedpans and sterilized needles. She also stated that nurse's aides and maids were allowed to perform injections and other services on African Americans that only licensed nurses could perform on Caucasian patients. Because of the things she witnessed at work she feels that the treatment at the hospital was a form of genocide to curb the African American population because the hospital staff did not care about African Americans. She continued to believe that hospitals do not care about African American patients as much as their Caucasian counterparts. Based on her experiences it is understandable for Mrs. Williams to still feel a certain amount of distrust for the system. It is likely that she has influenced her children's perspective of the health field and they in turn have done

the same with their children. Although the experiences may have not been directly witnessed by younger African Americans, the family thought pattern has been established and passed from generation to generation.

Experiences with mental health were not much better. Many African-Americans were forced into mental institutions against their will, subjected to experimental testing and denied their basic human rights (DeVise, 2005). This was displayed shortly after Crownsville Hospital Center was opened in 1911 originally called Hospital for the Negro Insane of Maryland. African American patients slept on straw and were restrained with chains in dark cells. Patients were also used to construct the first building and perform day to day work functions. Many patients were exposed to tuberculosis because a separate tuberculosis ward was not built for many years after one had been built in the Caucasian facility (Young, Hurd, Berkley, Hocking, Chatard, Armstrong, 1921). An example of this injustice is evident in the story of Godfrey Goffney. Goffney is listed as the thirteenth African American patient on the 1870 admissions register for Central State Hospital in Petersburg, Virginia, the first hospital created for the care of "insane Negroes." Mr. Goffney was committed to the facility with a diagnosis of "homicidal mania" and the supposed cause of his lunacy was freedom. A more detailed note related to his condition indicated that he "attempts to kill every white man" (Jackson, 2003).

Understanding how this history and the level of mistrust has shaped the current climate in therapy and the bearing it has on the current state of mind of African American clients is vital to providing competent therapy. Because of the constant, if unconscious, fear of unequal treatment by the majority culture, African Americans may have developed a unique psychology that requires special sensitivity and approach from the

counselor (Vontress & Epp, 1997). When a therapist takes into consideration the unspoken fears of an African American client it is clear why addressing race is an important aspect of building the therapeutic alliance. “Historical Hostility” is a phrase coined by Vontress & Epp (1997) that “implies in part that a collective African American consciousness exists that shares both the current frustrations and the memory of the sufferings the group has endured over time. Individual African Americans become assimilated into this consciousness through the overt and subliminal messages bestowed by their families, communities, music, religious rituals, and but the countless values, perceptions, and experiences derived from their unequal treatment in America (p. 173-174).” It is recommended by many therapists to have an honest conversation with clients about how race affects them but not expect clients to sum up their whole racial experience because it is more complicated than that. There are many aspects that influence how African Americans perceive racial problems. Personal experiences, family experiences, history and the media are just a few ways that a client can experience influences that pertain to their race (McGoldrick, Giordano & Garcia-Preto, 2005).

Many cultures have attitudes against therapy. In rural communities seeking therapy may make their neighbors think that they are crazy, Hispanic communities may view getting professional help as unnecessary (McGoldrick, Giordano & G arcia-Preto, 2005). African American people may view it as weak and something they should be able to handle (Thompson, Bazile & Akbar, 2004). They find alternatives to therapy. African Americans tend to rely on family, religious and social communities for emotional support rather than turning to health care professionals, even though this may at times be necessary (NAMI, 2009). They believe that the appropriate way to handle family

concerns is within the family. It appears to be foreign to tell private information to a person who has not earned trust. As a culture African Americans tend to view therapy as an invasion of their privacy and the privacy of the people close to them (Boyd-Franklin, 2006). African American men felt therapy could diminish pride and African American women felt that they must be the anchor and source of strength in the family; the historical expectation that life will be difficult because of race has permeated African American culture and has turned seeking help into a sign of weakness (Thompson, et al., 2004).

Another factor that keeps African Americans from therapy is a lack of knowledge about the mental health field. Financially, therapy is viewed as a luxury instead of a need (Thompson, et al., 2004) because of the lack of knowledge about affordable clinics to receive care many continue to harbor ideas of excessive fees and not seek therapy without actually checking the cost. It is also unknown when therapy is actually necessary. Some have trouble discerning what situation requires therapy or when a condition has reached a stage that it is necessary to receive help. This lack of knowledge also means that many do not know the signs of mental illness.

Religion is a very important aspect of life in the African American community. According to a Gallup Poll, African Americans are more religious than any other race or ethnic group in America (Newport, 2012). There are some people who have an either/or mentality, meaning someone must either believe that God will cure them of mental illness or their faith is not strong enough (Ellison, Boardman, Williams & Jackson, 1998). McCollough's (1999) review of the research on religion-accommodative counseling also indicated that a variety of religious involvement (e.g., regular church attendance, positive

religious attributions for life events, intrinsic religious motivation) was positively associated with measures of mental health (e.g., lower degrees of depressive symptoms, suicidal behavior), adding fuel to the belief that only faith, prayer, God and a pastor can "cure" someone.

In times of trouble many African Americans turn towards their religious leaders, pastors, reverends, bishops or deacons. This is even portrayed in the media (e.g., Sleepy Hollow, and Tyler Perry movies). It is viewed positively to turn to one of these people because to the public it reaffirms the belief that God can solve all problems (McGoldrick, Giordano & Garcia-Preto, 2005). More than any other helping resource, it has been argued that African American pastors are uniquely positioned to play two critical roles. The first is that of a primary mental health treatment source. The second role is that of a gatekeeper and referral source to specialty mental health care (Neighbors, Musick & Williams, 1998). The role of gatekeeper can be very subjective. If a pastor does not believe in the benefits of mental health professionals it is likely that he or she will perpetuate this pattern of thinking to their congregation. If, however, a pastor believed that a dual approach of prayer and formal mental health treatment was the most beneficial it is more likely that the pastor would be a good referral source and the congregation would feel comfortable discussing their mental health status with their pastor. Williams, Griffith, Young, Collins & Dodson (1999) asked clergy if they knew of a mental health agency to which they would feel comfortable making a referral. They also asked if African American clergy had ever referred any of their church members for help with a mental health related problem. They found that younger ministers were more open to referring their parishioners to specialty mental health care than older ministers.

Educational level was strongly related to referral, with 85% of clergy with a college degree reporting that they had actually referred clients to mental health services (Neighbors, Musick & Williams, 1998). Mental health is beginning to be accepted and education about mental health treatment will be essential in encouraging African Americans to enter into therapy.

Misperceptions

It is vital to acknowledge the misperceptions that potentially influence African Americans' not wanting to seek treatment. Therapists are trained to be sensitive to people of all cultures including their own. It is not uncommon for a therapist to learn basic information about minority clients as some therapists are not able to experience the culture firsthand. While this is a good practice it can also lead to a therapist stereotyping their clients. Research has been done to show that in some cases stereotypes do have an effect on the level of care that African Americans can receive when in mixed race dyads with a health care professional, this is called implicit bias. Stepanikova (2012) found that under high pressure, but not under low pressure, implicit biases regarding Blacks and Hispanics led to a less serious diagnosis. Implicit biases also led to a lower likelihood of a referral to specialist when physicians were under high pressure. Penner (2010) also found that medical interactions between Black patients and nonBlack physicians are usually less positive and productive than same-race interactions. Implicit biases of racial-ethnic inequalities have macro-level, historical, and socio-structural origins but at the same time they are maintained on the micro level through interpersonal interaction (Stepanikova, 2012). For example, a Caucasian therapist may learn from a professor that African American parents tend to be very strict and respect is important to the culture. With this information a therapist may apply this idea to every African American client without taking the time to understand their personal preferences

for respect. One class about culture is not enough to sustain a therapist for a lifetime. He/ She must always be open and seek knowledge to remain an effective therapist (Cardemil & Battle, 2003).

Along with cultural sensitivity it is important to encourage therapists not to paint an entire culture with the same brush. The therapist must also be sure to identify their own stereotypes about the African American population so as not to negatively affect therapy (Chang & Berk, 2009). In the 1990 General Social Survey (GSS) 44% believed that most African Americans are lazy, 56% endorsed the view that most African Americans prefer to live off welfare and 51% indicate that most African Americans are prone to violence (Williams & Williams-Morris, 2000). Negative stereotypes can cause a therapist to form an opinion about a client without taking the time to understand them which could lead to a misdiagnosis. African Americans in the United States are less likely to receive accurate diagnoses than their Caucasian counterparts (NAMI, 2009).

Transference is the phenomenon whereby we unconsciously transfer feelings and attitudes from a person or situation in the past or to a person or situation in the present (Hughes & Kerr, 2000). There are different possible transference reactions within the interethnic dyad, ranging from overcompliance and friendliness to suspiciousness and hostility (Comas-Díaz & Jacobsen, 1991). In a situation of overcompliance and friendliness clients may feel that they have to agree with the therapist so they are not labelled difficult and reinforcing negative stereotypes about their culture. For example, an African American woman may feel that she cannot challenge a therapist who is doing something that she does not agree with because she does not want to seem like an ‘angry black woman.’ On the other end of the spectrum is suspicion and hostility. How can this person understand me and what I have been through? This is a common thought in

interethnic dyads because it is impossible for a therapist to understand every experience of their client (Comas-Díaz & Jacobsen, 1991). An African American therapist will not understand the struggles of a Muslim client just as a Caucasian therapist would not understand all of the experiences of a Latino client. A driving force behind this mistrust and suspicion is unacknowledged ethnocultural differences (Comas-Díaz & Jacobsen, 1991). In both of these examples of transference reactions therapists could address these issues by an open discussion of race and culture.

Culturally sensitive therapy does not mean that a therapist must know everything about a culture but they must be willing to understand a client's frame of mind. Afraid of being judged, African Americans would rather stay silent than open up to a Caucasian therapist who they feel has no understanding of their way of life (Chang & Yoon, 2011). A decision that is made by a Hispanic or Asian person may not make sense to a Caucasian or African American person. Therapists must seek to understand that their judgment is not always correct or appropriate to someone else. For example, an African American boy may have gotten into a fight at school. Most people assume that it is never acceptable to fight and explain this to the family. The parents might disagree if they feel that their child was standing up for himself. It is not the therapist's place to tell the parents that they are wrong (McGoldrick, Giordano & Garcia-Preto, 2005).

Research on professional help seeking has consistently shown that people seeking professional help differ in important ways from those not seeking professional help (Broman, 1987). It has been suggested that African Americans do not seek counseling because they would rather remain private and consult with someone whom they know personally. These resources (e.g., familial, social and spiritual) are often accessed and

exhausted before turning to formal mental health systems to cope with distress (Wallace & Constantine, 2005). According to Wallace and Constantine (2005) higher levels of Africentrism were associated with greater perceived stigma about counseling and greater self-concealment. Self-concealment is the tendency to withhold personal, sensitive information that is thought to be negative. Privacy is valued in the African American community, which may affect discussing mental health with even immediate family members. Racial differences in stigmas may help to explain the lesser reliance on family and friends when discussing mental illness. African Americans may avoid discussing their distress with significant others because of doubts they hold about whether emotional problems are appropriate to disclose (Snowden, 1998).

Beneficial approaches

Many African Americans are fearful of having another racist encounter and many people do not want to be labeled a racist. How then is a therapist expected to bring up the subject of race without being insensitive and ruining the therapeutic relationship and how is an African American client expected to talk about racial issues with someone of a different race or the race that you are having difficulties with? Research has shown that bringing up the subject is important for building a healthy and honest therapeutic relationship (Thompson & Alexander, 2006). African American clients may feel uncomfortable disclosing information about a racial encounter out of fear of offending their therapist if race has not been addressed previously. It is important to recognize the fear on both sides of the issue. Research has found that the best way to deal with race is by inquiring with the client in a direct or indirect manner (Cardemil & Battle, 2003). Race has to be acknowledged in some way and the reason for doing so seems to

acknowledge the client and communicate to him or her comfort and trust with race differences (Boyd-Franklin, 2006). Acknowledgement of race in the therapy room is also intended to get the client to talk about it and for the therapist to assess how race and race differences with the therapist were important to the client (Fuertes, Mueller, Chauhan, Walker & Ladany, 2002). Multicultural clients need to know that their therapist will allow them to be open and discuss problems of race without judgment or offense.

In an article by Fuertes et. al. (2002) one of the skills identified as necessary to work with African American clients was to convey a sense of openness and acceptance of the historic effects of racism and the healthy mistrust that an African American client would bring to a counseling relationship with a Caucasian counselor. Research stated that African American clients may need more time to become comfortable with therapy (Fuertes et. al., 2002). Most clients are wary when entering therapy and this is more pronounced in African Americans as the culture tends to lean towards privacy and handling their problems within their immediate support group.

Including significant people in a client's life has been a normal practice in family therapy for many years. As noted earlier, African Americans are very collective in their thinking and grandparents, extended family, friends and pastors can play just as big a role in a person's life as a parent or sibling (McGoldrick, Giordano & Garcia-Preto, 2005). Respect is an important value in African American families (Dixon, Graber, Brooks-Gunn, 2008) and when including others in therapy it is important to the client that their therapist shows their loved ones the proper amount of respect as well. For example, in certain situations a pastor should be treated as another counseling professional because it

is possible that the pastor acted as their counselor at one point in time (Young, Griffith, Williams, 2003).

Therapists can sometimes rely too heavily on the models of therapy that they prefer without considering if that theory will work for their client as an individual. Many forms of therapy were developed through the experiences of Caucasian therapists working with Caucasian patients. Not many theories teach how to make the theory sensitive to multicultural clients and the situations that they may experience in life (Boyd-Franklin, 2006). The diversity of the United States requires that therapists examine if it is possible and how the theories used in therapy can be altered to cater to the needs of their multicultural clients (Ivey, 1995).

Researchers have recognized the need for therapists to be able to apply different theoretical techniques to each individual case (Sue & Zane, 2009). Santisteban, Coatsworth, Perez-Vidal, Mitrani, Jean-Gilles and Szapocznik (1997) discussed the importance using an approach called Brief Structural/Strategic Family Therapy when working with African American and Hispanic populations. This approach is present-focused and problem-oriented to meet the expectations of African Americans that therapy be relevant and lead to early concrete improvements. Using this approach, the therapist would have to deliberate and thorough during sessions. Many African Americans will feel that they are wasting time and money if a therapist cannot provide tangible proof that therapy is working. This technique was successful in engaging African Americans since it combines their cultural traits and social exchanges.

The goal of this qualitative study is to identify if there truly is reluctance in the African-American community, why the African-American community is reluctant, what

are the stigmas regarding mental health and therapy and what would help the problem. It is the hope that this study will provide added knowledge to therapeutic community so that they may make therapy more culturally relevant and appealing to African Americans. The need in the African American population is high and more culturally relevant therapy is necessary to attract and keep African American clients. The current literature has extensive information regarding African-Americans' relationship with therapy but what the literature does not address or define are the specific stigmas and stereotypes that make African-Americans reluctant to enter into therapy. This study attempts to address this gap. The researcher will examine the views of African-Americans who have not been in therapy on barriers and attitudes and beliefs about therapy seeking of African-Americans.

Chapter III

METHODS

The researcher used a phenomenological design for this study. A phenomenological study describes the common meaning for several individuals of their lived experiences about a concept or a phenomenon (Creswell, 2012). All the participants in this study have experienced the same phenomenon of being African American and potentially having reluctance to entering therapy. The researcher's goal of this study is to understand what African Americans feel and think about seeking mental health treatment such as therapy, how they experience it, and what factors influence their shared experiences.

Sampling and Data Collection, and Participants

The data from this qualitative study was collected from ten African-American men and women over the age of 19, who had not received therapeutic treatment. Participants were offered gift cards of 15 dollars, and the first to schedule an interview received a 25 dollar gift card to Target. Advertisements were posted in the Malone Centers, and churches around the Lincoln area. A snowball sampling and purposeful sampling method of data collection was used for the interviews. Snowball sampling is a sampling technique where existing study subjects recruit future subjects from among their acquaintances (Sadler, Lee & Lim & Fullerton, 2010) and purposeful sampling is a non-random method of sampling where the researcher selects information-rich cases for study in depth. Information-rich cases are those from which the researcher can learn a great deal about key issues of the research (Patton, 2001).

Participants scheduled an individual interview with the researcher that was approximately one hour. Interviews were recorded with an electronic recorder. Each participant signed a consent form to be recorded and included in the study. Participants had the choice of several different interview locations. Interview locations were the public library closest to the participant's home and a university library.

There were five female participants and five male participants with their ages ranging from 22-56. Half of the participants completed high school and the other half received their Bachelor's degree. Two participants were divorced, two participants were in a relationship and six participants were single. Their identified professions as: administrative assistant, teacher, nurse, FedEx dock worker, storage facility manager, military personnel, student, and unemployed. All participants identified themselves as Christian.

Data Analysis

The researcher utilized the data from semi-structured interviews (Appendix 1). The recorded interviews were then transcribed into written form so analysis could be made simpler. The researcher used an approach designed by Creswell (2012) to guide her data analysis. Open coding was an initial focus to allow for general categories to appear from the data. The researcher studied the data and recorded significant statements, sentences, or quotes that provided understanding of how the participants experienced the phenomenon (Creswell, 2012). Moustakas (1994) calls this step horizontalization. This allowed the researcher to develop clusters of meaning from the significant in-vivo statements into important concepts that would address the research questions.

After this was done, the researcher looked at the concepts that emerged from the process of open coding. The significant statements were then used to write a description of what the participants experience (textural description) and a description of the context or setting that influence how the participants experienced the phenomenon (structural description). Some examples of the textural descriptions from participants were descriptions of their experience with people who had been to therapy and how the people around them influence their own opinions about therapy, essentially the participant's description of what happened. Some examples of participant's structural descriptions are their descriptions of how these opinions and views came about which is the participant's views of how the experience happened. These statements were then analyzed for collective meaning and then grouped into larger units of information which formed the subcategories. All subcategories were organized into overarching categories that described the experience of the participants and described the reluctance to enter therapy. The researcher used this data analysis method because it allowed the freedom to explore the participant's responses but also provided organization that ensured results that were as unbiased as possible.

The Researcher as a Measurement Tool

At the start of this research, the researcher felt a special connection with this topic as she is a part of the African-American community. However, the researcher has tried to place her preconceived notions and stereotypes away and examine this topic from an academic framework instead of solely an emotional and personal viewpoint.

A major factor that led the researcher to investigate this topic was her apprehension to attend therapy even though she is a therapist. Even though she knows the

importance of therapeutic treatment she never felt that treatment was necessary for her own life. This juxtaposition of personal values versus professional values intrigued the researcher and enough to explore this topic more. While the researcher did allow academic research to lead she was able to draw from her own knowledge and experience of cultural influences on this topic to guide her initial hypotheses. As the researcher read and studied the available academic research her views began to grow more complex and holistic in nature.

Chapter IV

RESULTS

This study addressed four research questions (1) whether there is reluctance in the African-American community, (2) why the African-American community is reluctant, (3) what are the stigmas regarding mental health and therapy and (4) what would help break the barriers to professional help seeking. According to the data, yes, there is still reluctance among the African American population.

Four categories were identified in the data through multiple rounds of coding. The four categories are *stereotypes, lack of knowledge, reluctance and relatablility*. Themes that were developed based on these categories have provided further insight into why there is a continued reluctance in the African American population. Two themes emerged from the data of the study.

Table 1: Data Analysis Process from Specific to General

In-vivo Codes	**Subcategories**	**Categories**	**Themes**
Be strong enough, can handle it, it will pass, something you can do, you can, get over it, suck it up, control it, focus on other things	Personal responsibilities	**Stereotypes**	1. African Americans are reluctant to enter therapy and seek professional treatment because of cultural norms, such as reluctance to seek help, privacy, and negative views of therapy, that have been propagated into African American thinking 2. Fear of discrimination and race is not a factor that prevent African Americans from seeking therapy
Family, friends, secret, anonymity, family business, handle it on their own, won't spill guts, personal feelings	Private business		
Crazy, judgment, neighbors, psychotic, stigma, therapy means crazy	Crazy stigma		
Judgment, afraid, opinion on life, don't want to admit it, in your circle	Fear of judgment		
Psychotic break, extreme, overreaction, forced confinement, never try therapy, homicide, suicide	Intensity	**Hesitancy**	
Doesn't work, isn't working, doesn't need it, not worth it, talking is going to help	Being unnecessary		
Waste of money, too expensive, no insurance, not sure how much, won't pay to talk	Cost		
Black, African-American, White, race, can't say things, censor, cultural background	Race	**Relatability**	
Relatable, comfortable, ease the tension, connection, understand my issues, uncomfortable, feel weird	Comfort		
Confusion, misinformation, not sure, lacks knowledge, I don't know, they say, general idea, movies and TV, I think, little I know		**Lack of knowledge**	

The researcher read data transcripts numerous times and identified a list of repeated words or short phrases that were labeled as codes during the first round of open coding. Examples of such codes are *privacy, black people, friends and family, crazy, judgment, fear, and stereotype.* The code of black people referred to anytime a participant gave a general statement about the behavior of African Americans. The friends and family code was identified anytime a participant gave a statement that indicated they felt more comfortable discussing their problems with their friends and family. This code was eventually added to the subcategory of private business. Subcategories or patterns were further identified through comparing and integrating the initial codes. For example, there appears to be a pattern in participants' statements about suffering through their problems without the help of a therapist. This pattern was named subcategory of *personal responsibility* and further integrated into the *stereotype* category after reading and comparing all the codes of *stereotype*.

The *lack of knowledge* category emerged explicitly from the initial codes without going through a process of integrating subcategories. During the coding, the researcher noticed many participants' comments indicating misperceptions about therapy and the therapeutic process. The researcher coded these comments as lack of knowledge during the first round of open coding. This code was applied anytime a participant would give inaccurate information about therapy, express a misunderstanding about mental health or acknowledge that they did not know something about therapy. After this phase of coding the *lack of knowledge* category was large enough to be a standalone category.

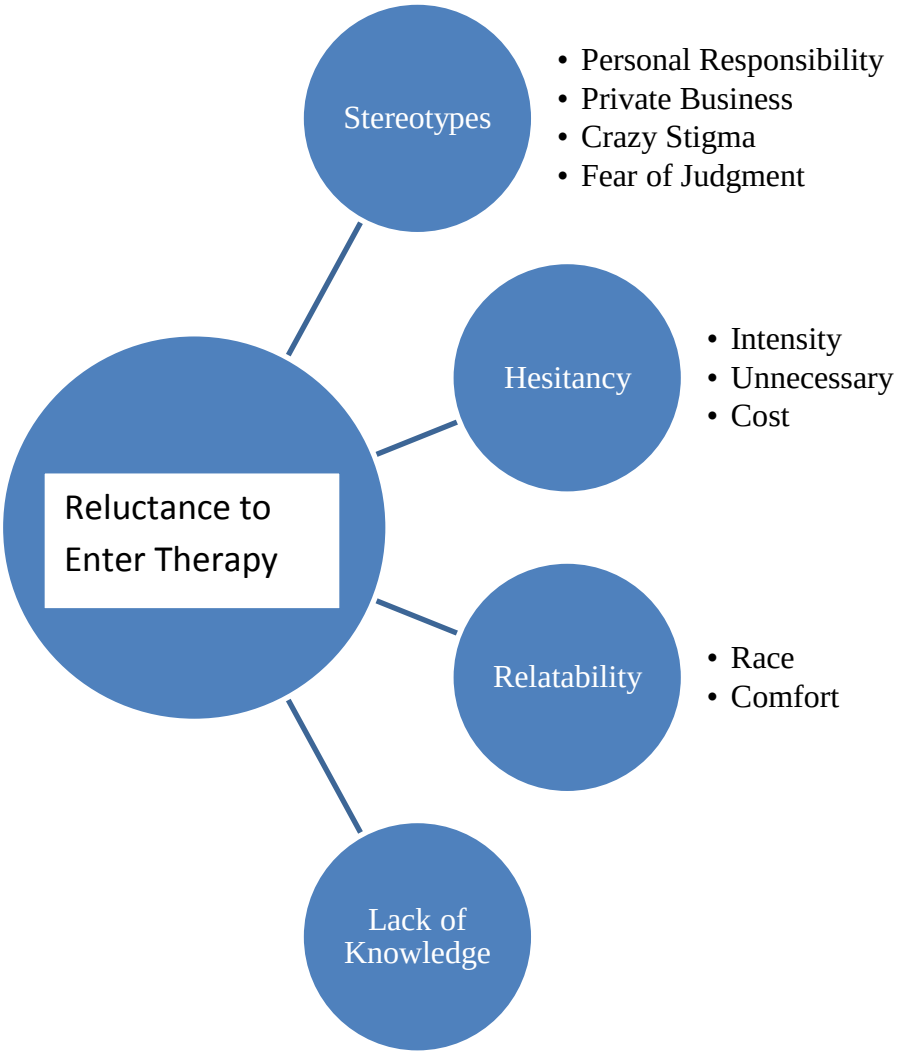
The *hesitancy* category was a difficult category for the researcher to conceptualize in the data. The names of the subcategories were not in vivo codes, i.e., participants'

words or phrases but the meaning behind the participants' statements. One such subcategory was *intensity* of participants' statements that was identified as suggesting an extreme view of therapy. This coding was intriguing because "extreme" is a relative term that can only be understood and readily identified in the context of this study. For example, a participant stated that nothing would be serious enough to convince him to enter therapy. The subcategory of *cost* was the number one reason why participants stated that they would not seek treatment. *Feeling strongly resistant and worrying about the cost* make participants *hesitant* to seeking therapy. The researcher's knowledge and mental health training led her believe that most did have some problems and could have benefited from therapy. Their current views help them back from seeking treatment.

Relatability was a category with two subcategories. This category was predominantly based in the participants' desire to feel a connection with a therapist. In the data participants had feelings of hesitancy and stated that having someone who they can have a connection with and would relate to them would ease their transition into therapy. The subcategories explain the main aspects of participant's concerns of relatability. The subcategory of race was based in participant's preference for a therapist who was of the same race because of the assumptions that a fellow African American would have some of the same experiences. The subcategory of comfort was created based on participant's statement about ways that a therapist could make them feel comfortable in therapy. Some participants stated that the therapist's communication style was just as important in helping them feel comfortable with the therapy process.

The figure below represents a relational diagram showing the key components of the reluctance of the African American population to enter therapy.

Figure 1. Coding for Qualitative Analysis



Stereotypes

It became evident that there was a strong connection between stereotypes and the lack of participation in therapy from the African American community. There were many references by participants regarding various stereotypes that made these so pervasive as to be related to their reluctance to enter treatment. There were four core stereotypes that were identified in the data to have played a role in keeping African Americans from

seeking therapy which were: personal responsibility for mental health, not wanting to discuss their private business, stigma of being crazy, and fear of judgment.

Personal Responsibility. In this study personal responsibility is defined as the participant's responsibility to manage their own mental health problems without the help or aid of a professional. Many participants in the study had a very strong do-it-yourself attitude when it came to handling life so they would not need therapy. Extensive studies have documented the help-seeking behavior of African-Americans (Broman, 1987; McGoldrick, Giordano & Garcia-Preto, 2005; Snowden, 1998; Thompson & Alexander, 2006). Participants in this study expressed that many African Americans view therapy as a last resort and that they must depend upon themselves to fix their problems. When discussing Anxiety as a diagnosis and a reason for going to therapy one of the participants commented that "I think if you're self-conscious individual and you're able to identify what exactly is causing the anxiety and then you can likely remove that from your life" another stated "in my mind there shouldn't be a reason that you can't control your anxiety I would probably say suck it up".

Private Business. Because of the stigma many participants have turned to their family and friends when they felt they could not handle their problems. A participant commented that "if I get depressed the people around me will help bring me out of it" and another participant commented "I feel that I can handle my own problems. That's it. If not, I will go to family and friends". The support system within the African American community is very strong and many participants felt that the best person to help with their problems were people who knew them. The participants indicated they would like to talk with friends or family first because they did not like the idea of telling their private

business to a stranger. One participant stated "I'm not really one for just talking to random people about my problems" and another said "I'm not just going to go in there and spill out my guts, I'm not that kind of person".

Crazy Stigma. The participants of this study believe there is a large mental health stigma in the African American community that makes seeking help a daunting experience. Many felt that if someone was seeking therapy and other people in their community knew, they would judge them for not being strong enough and they would also believe that they were 'crazy'. When one participant was asked if he knew anyone who had been to therapy and how much that person talked about it he responded that

> "It was more just, 'I'm in therapy'. Almost kind of testing the waters, seeing if there would be any judgment for them saying that they are in therapy since there is the stigma that anybody in therapy is a crazy person I think that is a typical stereotype for people going to therapy."

Fear of Judgment. Other participants could also recognize the risk of being judged by their peers for having mental health issues. One participant stated that "you don't want to tell the closest people you know, your friends and your family, because you're afraid of being judged". Some participants even displayed judgmental thoughts of people who seek treatment for reasons they did not deem serious enough. Participants stated such things as "anxiety is overrated", "people get over depression all the time" and "in my mind there shouldn't be a reason that you can't control your anxiety I would probably say suck it up". Some participants stated that judgmental attitudes still exist regarding mental health and other participants proved that it still exists.

Lack of knowledge

A theme that surfaced in the data was the lack of knowledge about the entire therapeutic process from where to find services to how much they cost. Seven participants recognized that they did not have much information regarding mental health services in their area and only three participants knew where they could go to receive therapy. Six participants mentioned that the cost of therapy was a major deterrent. One participant said "you expect to pay a lot of money [when you go to a therapist]". When asked, another participant stated that one session of therapy costs between $3000-4000. Depending upon the clinic, a typical therapy session can cost anywhere from $10-250. An estimated 19% of African Americans are uninsured (Finegold, 2013) and would not believe that they could afford therapy if they also believed it to be this expensive.

There was even less knowledge about how a therapy session was conducted. Many participants shared what, they pictured, a therapy session was like, "you sit and talk about your problems and then your therapist gives you advice and takes notes." Another participant stated "they [the therapist] sit down and talk about whatever the topic or problem is, they talk about it for an hour or however long the session is supposed to last and that's it". The data clearly reflected African American's reluctance of seeking therapy because of the lack of knowledge surrounding therapy and misconceptions about it.

Hesitancy

There were three contributing factors to the category of hesitancy which were: *intensity* for this study is defined as extreme reactions to the concept of therapy,

unnecessary is defined as participants, belief that therapy not vital and *cost* is regarding participants unwillingness to pay for therapy.

Intensity. Many participants stated that they would consider therapy but the reasons for which they would actually go were very intense. When asked what would make him consider going to therapy one participant responded simply by saying "nothing". Others were somewhat less extreme in their aversion to therapy by saying "It would have to be serious like a psychotic break" or "If I flipped out and had a panic attack one day if I had that one thing that would send me over the edge like if someone attacked me". Similar to the discussion in the stereotypes section African Americans tend to be self-reliant and only feel outside help is necessary when they cannot handle it. This thinking focuses more on cure than prevention.

Unnecessary. Participants viewed therapy was unnecessary for many different reasons, one participant said "that's [schizophrenia] something that drugs might help instead of talking to somebody" another stated that "I don't think anybody is going to take your fears away from you". With some participants already being wary of therapy their description of why someone would not need therapy makes sense. A participant said "I don't see that [depression] necessarily being a reason to go to counseling". Depression is a common mental disorder. Globally, an estimated 350 million people suffer from depression (World Health Organization, 2012). That is a lot of people who according to one participant should not seek treatment. Many do not believe in the effectiveness of therapy,

which they would not want to waste their money on if it is something that they could potentially fix themselves.

Cost. Money was a large factor in the reluctance to attend therapy. Even participants who had no reluctance to go to therapy would not consider seeking professional help because of the cost. Participants did not believe that paying for therapy was a priority. One participant stated that "you expect to pay a lot of money [when you see a therapist]". This is also connected to the lack of knowledge about therapy in general and where to locate cost appropriate services. Another participant commented "The only thing that will make therapy more appealing to black people especially low income black people is the price". Therapy cannot be completely free but there are services available that are affordable for most budgets and people without insurance.

Relatablility

A major factor that made participants reluctant was the thought of not being able to relate to a therapist. There were two themes that were found in this category: race and comfort. As a developing clinician, the researcher has realized that joining with a client is a major part of therapy. For clients, many would like to feel that a therapist can understand them and their point of view. Most importantly clients need to feel safe and comfortable with their therapist before true change can occur.

Race. Many participants expressed their desire to have a therapist who was of the same race as them because they felt they would inherently understand some of the experiences they have gone through. One participant stated "I would prefer the African American [therapist] because I am as well and they would experience the same things and

they can relate better to me about some things I have gone through". Some participants justified their preference of an African American therapist by also explaining why a Caucasian therapist would not be as helpful to them. One participant said "I kind of want to talk to a black person because there is just some things that you can't say to white people that (as) they won't get", another participant explained "in the back of your head you're wondering is this person going to be able to relate to me and understand my issues at all". These statements show that many African Americans are reluctant because many practitioners are not from diverse background that would make a client feel comfortable taking the first step by simply scheduling a session.

Another piece of the race theme was identified when the researcher asked the participants how they felt if a Caucasian therapist discussed race during their first session. While most therapists are instructed to discuss race during the intake process the participants indicated a different preference. Most participants stated that they would only feel comfortable if a therapist brought up the difference in their race if that was relevant to the reason they are seeking therapy. One participant stated "I would feel kind of weird if they [the therapist] themselves are bringing up as if it's a problem". This would imply that the therapist must be aware of how their good intentions could come off to a client if not performed well.

> "I would just want to know why. I feel like that shouldn't matter, whatever my problem is that's what I'm here to talk about. I'm not here to talk about my race I'm here to talk about said problem"

Comfort. Ensuring that a client feels comfortable enough to discuss important and private issues is a primary goal for all therapists. One participant commented

> "I believe that most people would choose something that is similar to them. They [African Americans] are already coming to the therapist with an issue about them and they may be overly conscious about it. So, I feel like to help ease the tension it would help with somebody who was similar to them so they would feel like they have more of a connection with them."

Making a client feel comfortable and express that the therapist can understand them is the most important first step in therapy. Joining is a primary concern. As stated previously in the stereotypes category African Americans tend to be very private and feel most comfortable sharing with someone they feel they know or can relate to. Therapists will not be able to provide effective therapy without first creating a strong bond with these clients.

Chapter V

DISCUSSION AND CONCLUSION

The results of this thesis point to two themes that are important to the body of knowledge surrounding African American reluctance to enter therapy. The first is African Americans are reluctant to enter therapy and seek professional treatment because of cultural norms that have been propagated into African American thinking and the second is fear of discrimination and race is not a factor that prevents African Americans from seeking therapy. As this sample was so small these finding are not generalizable to the entire African American population.

In this study the first theme that emerged from the data was many of the participants' aversion to therapy was influenced by cultural norms, meaning if an African American person grew up in a culture that viewed therapy in a more positive light they would not have as much reluctance. Culture is not equivalent to race. Many of the participants' answers were not based simply on the fact that they were African American but the fact that they had all grown up in a similar culture. As stated previously culture is a driving force behind our decision making. Boyd-Franklin (2006) found that many African Americans viewed therapy as an invasion of privacy. This study also supports that view as one of the subcategories discusses participants' hesitation to discuss personal matters with a therapist. According to this study the natural place for participants to seek help was from family and friends. As stated in the literature review, African American culture is very collectivist and in times of trouble many turn towards their support group rather than looking outside of this circle for professional help. Help-seeking attitudes in the African American community are another cultural norm that makes African

Americans hesitant to enter therapy. Thompson, et al. (2004) found that African Americans have become accustomed to the idea that life will be difficult and seeking help is a sign of weakness. Many participants felt that their mental health was their responsibility and that they should be able to control it. The belief that mental health can be controlled with sheer willpower is not true. Mental illness is a disease and if African Americans continue to feel that they must suffer through this burden without professional help there will not be any progress.

In this study the second theme that emerged from the data was fear of discrimination and race is not a factor that prevents African Americans from seeking therapy. As the pool of research evolves the researcher is confident that other scholars will come to believe this as well. In a study by Thompson, Bazile & Akbar (2004) it was found that it was common for African American culture to view going to therapy as weak. In a study by McGoldrick, Giordano & Garcia-Preto (2005) it was found that African Americans would rather seek the services of a religious leader. There were many reasons for why African Americans did not seek therapy but there were few reasons that were ruled out of the debate. The researcher found that fear of discrimination has very little to do with why they do not seek therapy from African American participants' perspective. Many participants felt that their race was not an issue that needed to be discussed and were under the assumption that a therapist of any race would feel similarly. Participants did feel that some therapists would not be able to fully understand their culture. Penner (2010) reported that medical interactions between Black patients and non-Black physicians are usually less positive and productive than same-race interactions. Stepanikova (2012) argued that institutionalized racial and historical inequality affected health care providers' decision when patients are minorities. They tended to receive poorer care

compared with their non-Black counterparts. It is worth noting that implicit biases of health care providers such as therapists could affect the interactions between therapists and clients, and the treatment African American clients receive, with or without their awareness.

As stated previously, cultural sensitivity is not knowing everything about a culture but being willing to accept other cultures' practices as being of equal value. Participants believed that this was more important to therapy than their race. The current study has found that while it is preferable it is not necessary to have a racially matched therapeutic dyad. Many participants stated that a racial match would make them feel more at ease when they come into therapy because that person would be similar to them in experiences. Additionally an African-American therapist would have a better understanding of culturally relevant behaviors and phrases. African Americans who live in predominantly White cities feel the same need to connect with something familiar which in this case is a person of the same race (Felton, 2012).

It is not the aversion to White therapists but the desire for something familiar that makes African Americans prefer African American therapists. This feeling is also experienced by people who travel outside of their home country. When in a different country the environment is unfamiliar and disconcerting, meeting someone from the same country while abroad forms an instant connection of something familiar and safe. This is even shown in groups designed specifically for finding other Americans abroad such as American Expat Network and The London Expat American Meetup Group. Both of these groups are ways to connect with other Americans while living in a foreign country. African Americans who live in predominantly White cities feel the same need to connect with something familiar which in this case is a person of the same race (Cabral & Smith, 2011).

Implications

One of the most important findings in this study was participants' lack of knowledge about therapy. Because many participants did not know basic information regarding therapeutic treatment they believed hearsay and media instead of facts. A participant felt that people with schizophrenia should be forced into treatment and if they did not want to seek treatment they were selfish. When asked why he felt this way he stated that they are a danger to people around them. Then he was asked how much he knew about schizophrenia and where that came from he stated that he did not know much and most of his ideas came from television. I know that this is an extreme case but because he has not had any experience or reliable information about schizophrenia he bases his conclusions off of misinformation and media bias. The lack of knowledge extends past media misperceptions as discussed in the literature review Thompson, et al. (2004) also found lack of knowledge about therapy is a major factor that keeps African Americans from pursuing treatment. Many tend to believe that it costs more than it really does, some do not know where to receive services and others do not know about its effectiveness. The validity of therapy is also dependent upon people's belief about mental health issues. As a result of this lack of knowledge many have a skewed view of what therapy is and the usefulness of it.

Another issue which is essential for a therapist to reflect on is how they will overcome an African-American client's reticence to discuss very personal matters. As discussed earlier in this study African-Americans tend to be private about their personal information and unwilling to share it with the outside world. For example, a therapist may ask why an African-American client has come to therapy and they would only get

bare minimum answer. The participants indicated that African-Americans often have difficulty expressing private information out of fear of being judged or believed that they are crazy. This would suggest that therapist must work harder to engage with their African-American clients and put special emphasis on the joining process. Participants identified that an African-American will begin to join with the therapist if they are understanding, relatable, patient and a good listener. It is important to make African-American clients feel that the therapist is not so formal that they cannot be comfortable around.

Many African-American clients tend to believe that therapy is something that is used as a last resort (Broman, 1987). This might extend to clients only coming to therapy in crisis or after they have already reached their breaking point. Participants identified problems that they would work through if they were currently in therapy and most of their problems are legitimate concerns to be therapy. However, because they are living functional lives they do not feel that these problems are serious enough to go to therapy. As a result it is not likely that a therapist would see many African-American clients until these current problems have developed into life altering ordeals.

Aspects of African American culture make therapy seem unnecessary. Other researchers (McGoldrick, Giordano & Garcia-Preto, 2005; Thompson, Bazile & Akbar, 2004; Boyd-Franklin, 2006) previously found aspects of African American culture that do not support therapy. This research is further supported by this study. The researcher found that culture is the driving force behind why African Americans are reluctant to enter therapy.

Limitations

As with any study, the research tried to eliminate all areas of concern and factor that might affect the subject in question. Despite this researcher's best efforts some limitations affected the results of the study. Researchers have stated that often an individual's experiences are processed in very subjective terms and can be explained as such through the data (Morgan & Smircich, 1980). Because this was a qualitative study the research is based off of the opinions of others, each participant has different life experiences which affect how they perceive the world and what they view as facts.

Another concept that could present itself in any research approach, not specifically qualitative, is participant bias, which is when a participant that's themselves in a way that they feel will fit in with what researchers looking for. The researcher made sure tell participants that she was only looking for their honest answer and there was no expected or "right" answer. This semi structured interview approach was put in place to ensure the researcher did not raise questions in a way that could be leading the participant to a particular answer.

Because this study was performed as a master's thesis the sample size was limited to ten participants in Lincoln, Nebraska. Because of the small sample size as well as the limited geographical location the sample may not be indicative of how the African American population as a whole experiences this phenomenon. More research is required with larger more diverse African American samples to be able to make generalizations to the population as a whole.

Implications for Clinical Work

One question that was asked in the study is if a participant would be made uncomfortable if a therapist of a different race discussed race in the initial session. Participants stated that unless they were in therapy for a situation that involved their race or the race of their therapist then they saw no reason to have that discussion. Many stated an aversion to it unless the therapist "did it right". There were some ways in which participants stated that would help the therapist discuss race.

The reason for discussing race must be made clear to the participant. A therapist simply asking if a client is comfortable with the difference in their races is not enough. Many participants implied that without a well-defined reason for why race is being discussed they would feel uncomfortable and most likely not return to that therapist or therapy at all. They stated that if not handled well this conversation would make them suspicious of their therapist's ability to work with an African American client.

There is so much data in qualitative research that cannot be expressed. The facial expression of a participant when they are asked a certain question or the passions in their voice when they gave an answer, the most passionate responses were given when participants were asked what the mental health field could do to make therapy more appealing. Many had very good ideas such as creating public service announcements, putting ads on television, provide information so people can learn that therapy is not always simply talk therapy. There are exercises, interventions and activities that can be done while in therapy.

There was one category that the researcher noticed that was not a contributing factor in why African Americans do not attend therapy which was progress. The progress

category was defined as any statement that a participant made that was progressive and portrayed a willingness to change their views on therapy or their already positive views on therapy. The researcher made this category strictly as a piece for discussion. According to this study there is still reluctance in the African American population but there is also progress that has been made that is important to discuss. Many participants stated that they would consider going to therapy. One participant stated that the only thing keeping her from therapy was the cost because she is "too cheap". This willingness shows that while there is still reluctance today there will be less reluctance in the future. With accurate information African Americans would be more willing to try therapy. During the study many participants learned new information about therapy and the researcher as able to discuss their misconceptions about therapy. Many appeared to be more willing to consider therapy with the accurate information than they did prior to the interview.

Overall, the researcher appreciates greatly to have had this study as a part of her clinical training and would encourage others in future training programs to be willing to explore their own culture as well as other cultures. It has allowed the researcher to study a piece of her culture and appreciate the complexities that it holds. It was also important to help others understand this culture and potentially examine their views of cultural identity. Most importantly the researcher hopes that this study will help the field become better able to connect with and encourage African American clients to participate in therapy.

APPENDIX 1

Interview Protocol

Each participant will be interviewed either at the Family Resource Center on East Campus, Love Library on City Campus, or a local library closer to their house to be more convenient. Each participant will sign a consent form to participate in the study and to be audio recorded. Each interview will be semi-structured so it will follow the basic format of interview questions but there is the option of asking probing questions if the researcher feels it is needed to clarify a point. Following the interview each participant will have the option of providing the researcher with their contact information if they would like to be emailed a copy of the finished study.

Interview Script

Welcome and thank you for your participation in my study. My name is Monique Williamson and I am a graduate student at the University of Nebraska- Lincoln studying Marriage and Family Therapy. This interview will take about an hour and will include 13 questions regarding your opinion on seeking therapeutic treatment. I would like your permission to tape record this interview, so I can accurately document the information you tell me. If at any time during the interview you wish to stop, please feel free to let me know. All of your responses are confidential. The purpose of this study is to increase our understanding of why the African American population has lower numbers of people who enter into therapy. In this study therapy is defined as treatment for mental and relational difficulties that occur in a person's life.

At this time I would like to remind you of your written consent to participant in this study. You will receive one copy of the consent form and I will keep the other. Do you have any questions before we begin? Then we will begin the interview.

Demographic questions

1. What is your age?
   _____ years
2. What is your gender?
   ___ Male
   ___ Female
3. What do you do for a living?
   _____
4. What is the highest level of education you have completed?
   _____
5. What is your religious preference?
   _____

Open-Ended Questions

1. What is your opinion on people receiving treatment for the following mental health and relationship issues?
    a. Depression
    b. Anxiety
    c. Schizophrenia
    d. Bipolar disorder
    e. Marital problems
2. Do you know anyone who has been to therapy?
3. What would make you consider going to therapy?
4. If you wanted to go, do you know where services are available?
    a. If not
        i. How would you go about finding services?
5. Describe your image of a therapist.
6. How does race matter in the selection of a therapist?
    a. If you had the choice between an African American therapist and a Caucasian therapist would you prefer the AA therapist?
    b. Why or why not?
7. How would you feel if a therapist of a different race or ethnicity discusses race or ethnicity during the initial phase of therapy?

8. Tell me about the characteristics you would want your therapist to have?
9. If you did enter therapy what would be your goals?
10. Tell me about some of your objections to seeking therapy?
11. What do you believe the African American community thinks about mental health and therapy?
12. What do you know think happens in therapy?
13. How much do you think therapy costs?
14. What would make therapy more appealing to you?

That is all of the questions that I have for you today. Is there anything that you would like to add or clarify before we conclude? Do you have any questions for me?

Thank you for your time I appreciate your time and honesty.

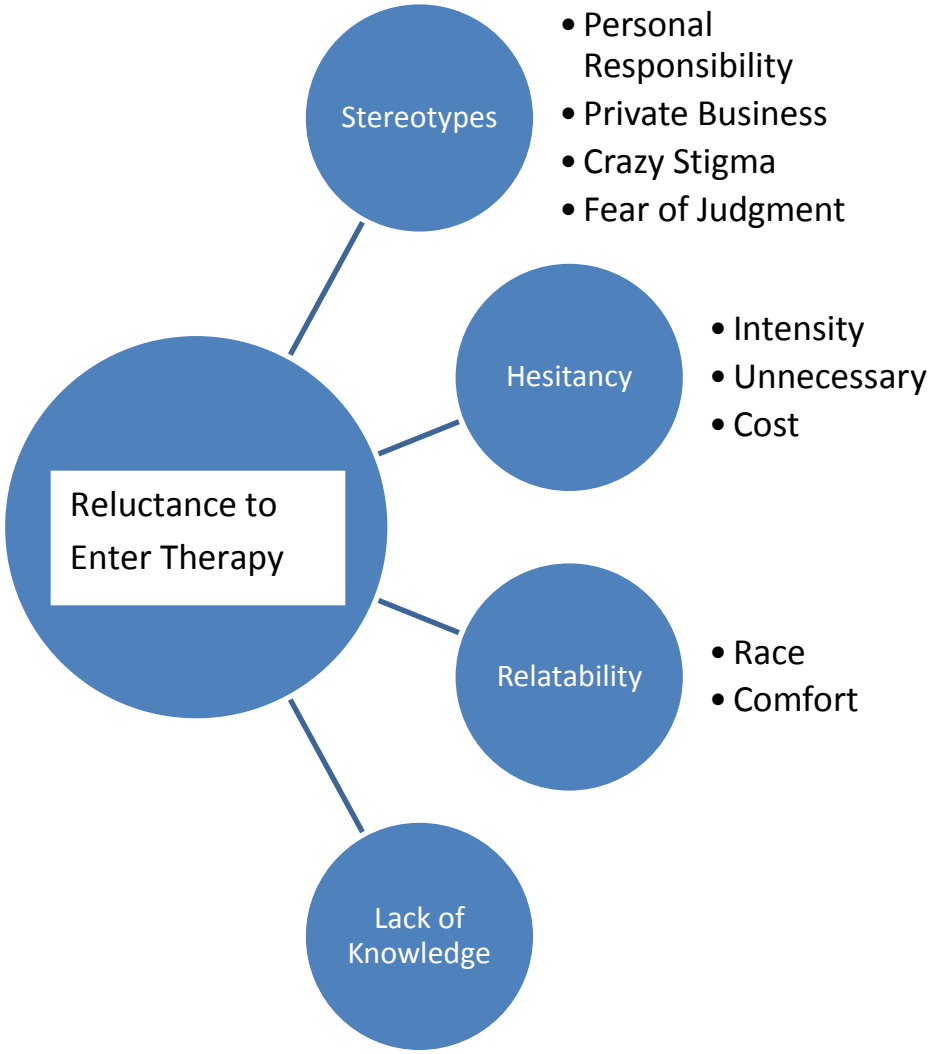
APPENDIX 2

Table 1: Data Analysis Process from Specific to General

In-vivo Codes	**Subcategories**	**Categories**	**Themes**
Be strong enough, can handle it, it will pass, something you can do, you can, get over it, suck it up, control it, focus on other things	Personal responsibilities	**Stereotypes**	1. African Americans are reluctant to enter therapy and seek professional treatment because of cultural norms that have been propagated into African American thinking 2. Fear of discrimination and race is not a factor that prevent African Americans from seeking therapy 3. With accurate information African Americans would be more willing to try therapy
Family, friends, secret, anonymity, family business, handle it on their own, won't spill guts, personal feelings	Private business		
Crazy, judgment, neighbors, psychotic, stigma, therapy means crazy	Crazy stigma		
Judgment, afraid, opinion on life, don't want to admit it, in your circle	Fear of judgment		
Psychotic break, extreme, overreaction, forced confinement, never try therapy, homicide, suicide	Intensity	**Hesitancy**	
Doesn't work, isn't working, doesn't need it, not worth it, talking is going to help	Being unnecessary		
Waste of money, too expensive, no insurance, not sure how much, won't pay to talk	Cost		
Black, African-American, White, race, can't say things, censor, cultural background	Race	**Relatability**	
Relatable, comfortable, east the tension, connection, understand my issues, uncomfortable, feel weird	Comfort		
Confusion, misinformation, not sure, lacks knowledge, I don't know, they say, general idea, movies and TV, I think, little I know		**Lack of knowledge**	

APPENDIX 3

Figure 1. Coding for Qualitative Analysis



REFERENCES

American Psychological Association. (2010). Race/Ethnicity of Doctorate Recipients in Psychology in the Past Ten Years: 2010. Retrieved from: http://www.apa.org/workforce/ publications/10-race/2010-doctorate-race.pdf

Boyd-Franklin, N. (2006). *Black families in therapy: Understanding the African American experience*. Guilford Press.

Brandt, A. M. (1978). Racism and research: the case of the Tuskegee syphilis study. *Hastings Center Report*, *8*(6), 21-29.

Broman, C. L. (1987). Race differences in professional help seeking. *American Journal of Community Psychology*, *15*(4), 473-489.

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, *58*(4), 537.

Cardemil, E. V., & Battle, C. L. (2003). Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. *Professional Psychology: Research and Practice*, *34*(3), 278.

Cepeda-Benito, A., & Short, P. (1998). Self-concealment, avoidance of psychological services, and perceived likelihood of seeking professional help. *Journal of Counseling Psychology*, *45*(1), 58.

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. Journal of counseling psychology, 56(4), 521.

Comas-Díaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry*, *61*(3), 392-402.

Coon, H. M., & Kemmelmeier, M. (2001). Cultural orientations in the United States: (Re) Examining differences among ethnic groups. *Journal of Cross-Cultural Psychology*, *32*, 348– 364.

Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches*. Sage.

De Vise, D. (2005). *Studying a relic of a painful past.* Washington Post. Retrieved from: http://www.washingtonpost.com/wp-dyn/content/article/2005/08/11/AR2005081101821.html

Dixon, S. V., Graber, J. A., & Brooks-Gunn, J. (2008). The roles of respect for parental authority and parenting practices in parent-child conflict among African American, Latino, and European American families. *Journal of Family Psychology*, *22*(1), 1.

Felton, E. (2012). Maintaining connection overseas. Online Opinion, 1-1.

Finegold, K. (2013). ASPE Issue Brief. U.S Department of Health and Human Services. Retrieved from http://aspe.hhs.gov/health/reports/2013/CPSIssueBrief/ib_cps.cfm

Fuertes, J. N., Mueller, L. N., Chauhan, R. V., Walker, J. A., & Ladany, N. (2002). An investigation of European American therapists' approach to counseling African American clients. *The counseling psychologist*, *30*(5), 763-788.

Green, B. L., Maisiak, R., Wang, M. Q., Britt, M. F., & Ebeling, N. (1997). Participation in health education, health promotion, and health research by African Americans:

effects of the Tuskegee Syphilis Experiment. *Journal of Health Education, 28*(4), 196-201.

Hughes, P., & Kerr, I. (2000). Transference and countertransference in communication between doctor and patient. *Advances in Psychiatric Treatment*, *6*(1), 57-64.

Ivey, A. E. (1995). Psychotherapy as liberation: Toward specific skills and strategies in multicultural counseling and therapy. *Handbook of multicultural counseling*, 53-72.

Jackson, V. (2003). Separate and Unequal: The Legacy of Racially Segregated Psychiatric Hospitals: A Cultural Competence Training Tool.

McCullough, M. E. (1999). Research on religion-accommodative counseling: Review and meta-analysis. Journal of Counseling Psychology. *46*, 92-98.

McGoldrick, M., Giordano, J., & Garcia-Preto, N. (Eds.). (2005). *Ethnicity and Family Therapy*. Guilford Press.

Mental Health America. (1996). African American Communities and Mental Health. Retrieved from: http://www.www.mentalhealthamerica.net/african-americanmental-health

Morgan, G., & Smircich, L. (1980). The case for qualitative research. *Academy of management review*, *5*(4), 491-500.

Moustakas, C. (Ed.). (1994). *Phenomenological research methods*. Sage.

National Alliance on Mental Illness. (2009). African American Community Mental Health Fact Sheet. Retrieved from: http://www.nami.org/Template.cfm?Section=Fact_&Template=/ContentManagement/ContentDisplay.cfm&ContentID=53812

Neighbors, H. W., Caldwell, C., Williams, D. R., Nesse, R., Taylor, R. J., Bullard, K. M., & Jackson, J. S. (2007). Race, ethnicity, and the use of services for mental disorders: results from the National Survey of American Life.*Archives of general psychiatry*, *64*(4), 485-494.

Neighbors, H. W., Musick, M. A., & Williams, D. R. (1998). The African American minister as a source of help for serious personal crises: bridge or barrier to mental health care?. *Health Education & Behavior*, *25*(6), 759-777.

Newport, F. (2012). Seven in 10 Americans are Very or Moderately Religious. Retrieved from http://www.gallup.com/poll/159050/seven-americans-moderately-religious.aspx

Nickerson, K. J., Helms, J. E., & Terrell, F. (1994). Cultural mistrust, opinions about mental illness, and Black students' attitudes toward seeking psychological help from White counselors. *Journal of Counseling Psychology*,*41*(3), 378.

Oral History Interview with Mabel Williams, August 20, 1999. Interview K-0266. Southern Oral History Program Collection (#4007) in the Southern Oral History Program Collection, Southern Historical Collection, Wilson Library, University of North Carolina at Chapel Hill. Retrieved from http://docsouth.unc.edu/sohp/K-0266 /excerpts/ excerpt _8777.html #citing

Patton, M. (2001). Qualitative Research & Evaluation Methods. Thousand Oaks, CA: Sage Publications.

Penner, L. A., Dovidio, J. F., West, T. V., Gaertner, S. L., Albrecht, T. L., Dailey, R. K.,

& Markova, T. (2010). Aversive racism and medical interactions with Black patients: A field study. Journal of experimental social psychology, 46(2), 436-440.

Sadler, G. R., Lee, H. C., Lim, R. S. H., & Fullerton, J. (2010). Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nursing & health sciences*, *12*(3), 369-374.

Santisteban, D. A., Coatsworth, J. D., Perez-Vidal, A., Mitrani, V., Jean-Gilles, M., & Szapocznik, J. (1997). Brief structural/strategic family therapy with African American and Hispanic high-risk youth. *Journal of Community Psychology*, *25*(5), 453-71.

Solorzano, D., Ceja, M., & Yosso, T. (2000). Critical race theory, racial microaggressions, and campus racial climate: The experiences of African American college students. *Journal of Negro Education*, *69*(1/2), 60-73.

Snowden, L. R. (1998). Racial differences in informal help seeking for mental health problems. *Journal of Community Psychology*, *26*(5), 429-438.

Stepanikova, I. (2012). Racial-ethnic biases, time pressure, and medical decisions. Journal of health and social behavior, 53(3), 329-343.

Sue, S., & Zane, N. (2009, August). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. In *Asian American Psychological Association Convention, Aug, 1985, Los Angeles, CA, US; The first author presented an earlier version of this article as an invited address at the aforementioned conference.* (No. 1, p. 3). Educational Publishing Foundation.

Thompson, V. L. S., & Alexander, H. (2006). Therapists' race and African American clients' reactions to therapy. *Psychotherapy: Theory, Research, Practice, Training*, *43*(1), 99.

Thompson, V. L. S., Bazile, A., & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice*, *35*(1), 19.

Turner, R. J., Lloyd, D. A., & Taylor, J. (2006). Physical disability and mental health: An epidemiology of psychiatric and substance disorders. *Rehabilitation Psychology*, *51*(3), 214.

U.S. Census Bureau. (2010). Overview of race and Hispanic origin:2010. Generated by Humes, K., Jones, N., & Ramirez, R. Retrieved from: http://www.census.gov/prod/ cen2010/briefs/c2010br-02.pdf

U.S Department of Health and Human Services. (2013) National Healthcare Disparities Report. Vontress, C. E., & Epp, L. R. (1997). Historical hostility in the African American client: Implications for counseling. *Journal of Multicultural Counseling and Development*, *25*(3), 170-184.

Wallace, B. C., & Constantine, M. G. (2005). Africentric cultural values, psychological help-seeking attitudes, and self-concealment in African American college students. *Journal of Black Psychology*, *31*(4), 369-385.

Williams, D., & Williams-Morris, R. (2000). Racism and mental health: the African American experience. *Ethnicity and Health*, *5*(3-4), 243-268.

Williams, D. R., Griffith, E. E., Young, J. L., Collins, C., & Dodson, J. (1999). Structure and provision of services in Black churches in New Haven, Connecticut. *Cultural Diversity and Ethnic Minority Psychology*, *5*(2), 118.

World Health Organization. (2012). Fact Sheet N 369. Retrieved from: http://www.who.int/ mediacentre/factsheets/fs369/en/

Young, J. L., Griffith, E. E., & Williams, D. R. (2003). The integral role of pastoral counseling by African-American clergy in community mental health. *Psychiatric Services*, *54*(5), 688-692.

Young, H., Hurd, H., Berkley, H., Hocking, G. Chatard, J. A., Armstrong, A. (1921). Biennial Report of the Lunacy Commission. State of Maryland.