This is to certify that the
dissertation entitled

A QUALITATIVE ANALYSIS OF PROFESSIONAL PSYCHOLOGICAL HELP-SEEKING ATTITUDES AMONG AFRICAN AMERICAN WOMEN

presented by

Paula Michelle Mitchell

has been accepted towards fulfillment
of the requirements for the

Ph.D. degree in Counseling Psychology

Lea T. June
Major Professor's Signature

8/8/2004
Date

A QUALITATIVE ANALYSIS OF PROFESSIONAL PSYCHOLOGICAL HELP-SEEKING ATTITUDES AMONG AFRICAN AMERICAN WOMEN

By

Paula Michelle Mitchell

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Counseling, Educational Psychology, and Special Education

2004

ABSTRACT

A QUALITATIVE ANALYSIS OF PROFESSIONAL PSYCHOLOGICAL HELP-SEEKING ATTITUDES AMONG AFRICAN AMERICAN WOMEN

By

Paula Michelle Mitchell

The purpose of this qualitative investigation was to elicit and explore the range of definitions, thoughts, and feelings held by African American women relative to mental health care in general and in relation to themselves to expand and clarify what generally motivates and/or deters African American women from seeking professional mental health care in instances of psychological distress. Overall, this investigation sought to identify issues pertinent to African American women and their attitudes toward counseling and/or therapy as they affect patterns of mental health care utilization. Semi-structured interviews were conducted with 8 low to upper middle-income African American women 21 - 55 years of age. Constant comparative methods were used to analyze data emanating from the interviews. The results revealed 4 major themes: (a) It Doesn't Work, (b) My Way Works Just Fine, (c) No More Than I Can Bear, and (d) Community Perceptions. Illustrative quotations from participants are presented and implications for practice and future research are discussed.

This dissertation is dedicated in memory of my father. Daddy, I know that you have been and will continue to be with me always. I treasure each and every moment that we shared while you were here and I continue to cherish each and every moment that I know you are near. I have appreciated all of your guidance and faith in me. You are my perfect father and will continue to be as I will always remember your wisdom. Thank you and I love you.

ACKNOWLEDGMENTS

This dissertation could not have been possible without the assistance and support of my advisor, Lee June, Ph.D. as well as my other committee members, Gloria Smith, Ed.D., Retumetse Mabokela, Ph.D., and John Sweitzer, Ph.D. Dr. June, thank you for your consistent words of encouragement and reassurance. I remember meeting with you every week while in preparation of my proposal. It means so much to me that despite your "1 million" other obligations to approximately 43,000 undergraduate, graduate and professional students, you made time. At the end of every meeting, you would say to me with a smile, "Are you excited?" I must admit that there were definitely instances in which I was not excited about the job that lay before me as I thought of leaving your office and heading strait to the library. Yet in those moments, I was able to see your excitement and as a result, for an instant before I began my hike to the library with my 50-pound backpack, I was able to relish in the adventure that was yet to come. When the next phase of this process began, I found it difficult to write from afar, however, you always made sure that you were accessible. Thank you for your gentle push to "get this done." I appreciated and found myself excited on many occasions to discover what words of inspiration you had to offer at the end of your correspondence. Thank you. You've been so helpful. To Dr. Mabokela, what can I say? You have been so supportive, caring, advocating, and so much more throughout my academic career at Michigan State University. You don't know how much you have meant to me. I remember feeling so anxious about

asking you to be apart of my guidance committee years ago. Straight away, I felt comforted in knowing that you were "on my side." I felt instantly that you wanted me to succeed and that you would be there to mentor me in whatever capacity I needed. Thank you. Thank you for listening to my "madness" when I was "freaking out" about my data. "Data overload" to be exact. Thank you for being my calm in the mist of my craziness. I have greatly appreciated your words of encouragement and just the right amount of pressure . . . just enough to continue to be motivated and excited about the "light at the end of the tunnel" that finally, I began to see very recently. I would also like to thank my "biggest fan," my mother, for her unwavering support, frequent and "on time" phone calls, encouragement, and thank goodness for me, what seemed to be a bottomless pit of a wallet. Thank you for your excitement and pride. Thank you for prayers every night and endless showing of "I love you as high as the sky and as deep as the ocean." When no one else could, you always would. Thank you for being there and stroking my pride when I needed it the most. Thank you for your "what do I need to do . . . how can I help" way of thinking. Thank you for coming to see me and cooking and cleaning up my apartment, and holding your tongue when you truly wanted to ask, "why does your apartment look like this?" or better yet, "why does your hair look like that?" Thank you for allowing me to, "get some rest" as you would say and waiting on me hand and foot when you knew I was tired when I came to visit my sunny little family in sunny Houston. Thank you for supporting me in life and in this "last leg" of the "doctoral race." I would like to thank my furry friend, Jua, for his love and attention, endless lap time and affection, and his

warm "welcome home" after those late dissertation nights. Oh, and Mommy, thank you for recognizing how special he was to me after my second visit to the pet store and ultimately saying, "buy him and I will send you the money," when you knew that I couldn't afford him. I know that truly, nothing has been possible without your amazing and perfect in every way, support. To my best friend, my significant other, my editor, my teacher, my genius, my soul mate . . . I love you. Thank you for believing in me in ways that I was unable to believe in myself . . . "you may not believe that you can do it but I know you can." Thank you for sacrificing to help over and over again. Thank you for countless instances of you doing whatever it takes to make me smile. Thank you for wanting to be a better person and going through the trials and tribulations to become such a wonderful man. Thank you for your encouragement, loving surprises, and knowing me so well. Thank you for putting up with my continual and often painful, not only for me but you as well, journey of discovery and self-knowing. Thank you truly for your support and love. Thank you for helping me to see "the bigger picture," always. Thank you for being here . . . in my life. I would also like to thank all of the staff (family) of my internship program at the Howard University Counseling Service for their support, understanding, and "whatever you need" attitude throughout this process. I could not have found a better "match." I have greatly appreciated all of the nurturing, love, and family caring that I have received from each and every one of you. Thank you for making me a better person and a better psychologist through not only your conventional teaching but also helping me to get to a place where I could "process" and begin to uncover and realize my "self" as a person,

psychologist, and a professional. To my fellow interns, my sister and brother, I love you both more than you could ever know. It has been quite a journey of both immense joy and a little pain to boot. We will continue to share many memories as we have throughout this year and throughout the rest of our personal and professional lives. Thank you Maia ("Mai" to me) for showing me how to "stretch myself" and give a little more. We have had an exhausting time but never gave up and continued to work and to our surprise, we figured it out. Our children will surely play together. I'll always remember to send you chocolate. To Andrae', well, what do I say. Thank you for being so genuinely good. Thank you for your kind and endlessly giving heart. Thank you for being so caring and loving. Thank you for being my true friend. A handshake and a snap.

PREFACE

My mother has an endless list of colloquialisms, a timely one or two for every mishap and frustrating situation. "People in hell want ice water," "better to be pissed off than pissed on," "stop robbing Peter to pay Paul," "cute will kill you," "walk with lions but never loose the common touch," and my personal favorite, "God don't like ugly." But the one that I have come to hear most in my life during the short time that I have known this woman (twenty-nine years) has to be "God does not put on us more than we can bear." The scripture that my mother is referring to reads as follows:

> There hath no temptation taken you but such as is common to man: but God *is* faithful, who will not suffer you to be tempted above that ye are able; but will with the temptation also make a way to escape that ye may be able to bear *it*. (1 Cor. 10:13 King James Version).

It seems that every Black woman has heard this or some derivative of this phrase from her mother, grandmother, great grandmother, aunt or some other female family member. In a few words, this scripture possibly captures the heart of the continued existence of the African American community. Specifically, faith has provided emotional support in the face of uncertainty and consolation in the face of disappointment (O'Dea, 1966). It is this force which has given strength to endure when endurance does not give promise (Lincoln, 1974). Yet as an African American, a woman, and a "budding" psychologist, I eventually became interested in the mental health system and it's role and ability to address the

psychological distress and symptoms emanating from the circumstances that occupy African Americans and African American women in particular. However as an undergraduate student of psychology in a Midwestern predominantly European American university during the early to mid 1990's, I never questioned the capacity of the Western paradigms from which I was trained, to provide an understanding and explanation for the psychological functioning and behavior of "all persons." I never doubted whether these frameworks could sufficiently address the presenting issues and concerns of persons of color and women of color specifically. It was not until I entered the "Mecca," (Howard University) during the fall of 1997 as a Masters of Education student in Counseling Psychology that I began to learn of and observe for myself the gaps and weaknesses of these traditional frameworks. In consequence, I quickly and adamantly began to search for and study alternative paradigms, methods, and strategies and their potential to more accurately and appropriately explain and address the concerns of African American women. I found that the system had fallen short of providing, as it should. It seemed that the African American community and their low rates of mental health service utilization, was "hip" to the inadequacies and limitations of the mental health system. It appeared that from the community's vantage point, the mental health establishment did not "speak" to its members' existence. If we could create a better system of care, what would this system look like? What would be different? My questions instantly led me in search of the kind of mental health services that would be most appropriate and appealing to African American women. I quickly found that while asking, "Which

do you choose," my subjects responded, "I don't." This response forced me to "step back" in my thinking. In response, the following study emerged.

TABLE OF CONTENTS

CHAPTER I

Introduction

> For this, their promise, and their hard past, I honor the women of my race.
> W.E.B. Du Bois (1969, p. 185)

Rationale for the Study

What generally motivates or deters people from seeking out mental health services? This question is fundamental as many of those who are most in need of counseling and/or therapy never receive those services (Kessler, McGonagle, Zhao, Neson, Hughes, Eshleman, Wittchen, & Kendler, 1994). It is the general consensus that those who choose to make use of professional psychological care are those typically in crisis and/or only in instances in which other means of support have been depleted (Morris, 2001). Exploring issues significant to decisions of whether or not to seek out counseling and/or therapy may help alleviate factors preventing people from seeking formal care in instances of personal and emotional distress (Komiya, Good, & Sherrod, 2000). According to Komiya and colleagues (2000), without this information, mental health professionals are left without a sound understanding of how people go about making decisions to ultimately seek counseling and/or therapy and are consequently unable to effectively reach those who are most in need. This dearth of information thus results in the system's inability to appropriately respond to negative attitudes that disrupt or prevent the link between potential clients/patients and providers and accordingly to needed care (Komiya et al., 2000).

Though attempts have been made to uncover pertinent issues affecting the professional psychological help-seeking attitudes and behaviors of the population "at large," exploration relative to certain sectors of the population remains deficient. The research that has been done fails to focus on differences between groups opting instead to focus on assumed applicability to all segments of the population (Dana, 2002). This perspective is problematic as there are distinctive social and cultural issues pertinent to certain sectors of the population that may contribute to a divergent understanding of the professional psychological help-seeking attitudes of these groups. This understanding becomes increasingly significant as society is becoming more and more multi-ethnic. After all, in addition to the everyday stresses experienced by the general population, racial/ethnic groups encounter personal and institutionalized racism, prejudice, and discrimination (Sue & Sue, 1990); experience absolute and relative poverty (O'Hare, Pollard, Mann, & Kent, 1991); and generally have poorer physical and mental health (Schulz, Israel, Williams, Parker, Becker, & James, 2000). One way of explaining these circumstances is through the use of social psychological stress theory (Pearlin, Lieberman, Menaghan, & Mullan, 1981). This theory proposes that certain stressors fall disproportionately on certain sectors of the population (minority groups), especially those experiencing more life changes, however, have fewer resources available to cope with those changes. Yet notwithstanding strong associations between racial/ethnic group status and high levels of physical and emotional stress, these communities consistently under utilize professional sources of mental health care (Vega &

Rumbaut, 1991; Taylor, 1999). Thus, the extent to which current mental health service utilization is congruent with need is disproportionate (Neighbors, 1984). Underutilization patterns are thought to reflect perceptions of services as inaccessible, undesirable, or a lack of awareness of need (West, Kayser, Overton, & Saltmarsh, 1991). In opposition of making use of professional services, many opt instead, particularly African Americans, to utilize informal resources (i.e., religious attendance, practice, or activity) (Neighbors, 1985). Those that do have a much higher drop out rate (Sue, 1977; Acosta, 1980; Flaskerud & Hu, 1992) or have less positive treatment outcomes than do other groups (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Irrespective of these findings, however, there remains a paucity of research devoted to understanding the complexity of these issues. As such, it becomes of great significance to continually exert energy into advancing our understanding of the attitudes affecting patterns of mental health care utilization among persons of color.

One group in particular need of exploration is African American women (Mays & Comas-Diaz, 1988; Mays, 1995; Mays, Caldwell & Jackson, 1996). Though women generally tend to hold more favorable attitudes toward counseling and/or therapy and have higher rates of use than do men (Gibbs & Fuery, 1994), in comparing European American and African American women, African American women have lower rates of use and higher rates of premature termination (Terrell & Terrell, 1984). Given the magnitude of stress that African American women experience increases their vulnerability for developing psychological illness (Jackson & Sears, 1992). For instance, according to the

Epidemiological Catchment Area (ECA) study sponsored by the National Institute of Mental Health, African American women have the highest rates of schizophrenia, somatization, generalized anxiety disorder, and phobia being the population's most frequently occurring mental disorder when compared to other racial/gender groups (Robins, Helzer, Croughan, & Ratcliff, 1981). A latter survey, the National Comorbidity Survey (NCS), also funded by the National Institute of Mental Health, found that African American women have the highest rates of agoraphobia, dysthymia, mania, simple phobia, post-traumatic stress disorder, and as in the ECA study, the highest rates of schizophrenia when compared to African American men and European American men and women (Kessler et al., 1994). Though mental health professionals are more likely to come into contact with women than men as women are more inclined than men to recognize and label nonspecific feelings of distress as emotional problems worthy of professional help, to date the distinctive concerns of African American women have not yet been priorities in multicultural research (Frame, Williams, & Green, 1999). Exploration in this area may outline essential information relative to the initial willingness or lack thereof of African American women to seek out professional psychological help. As a result, this understanding will foster further movement toward an understanding of how best to reach this population through responding to their reluctance to enter the mental health care system (Snowden & Hines, 1999).

Existing research has generally failed to identify consistent and specific barriers and incentives to seeking out formal mental health services and lack

opportunities to elicit direct explanations of behaviors and perceptions of barriers (i.e., survey measures provide options to choose from) (Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003). The limitations of previous survey research speak to the need for alternate research methods in order to attain a more thorough conception of the specific professional psychological help-seeking attitudes, variables associated with such help-seeking, and a more descriptive and comprehensive look at the decision-making process of seeking out mental health care (Timlin-Scalera et al., 2003). As such, to obtain such in-depth information, a qualitative design was chosen for the purposes of this study.

Statement of the Problem

Given the precarious conditions that face African American women, it becomes of utmost importance to create a system providing mental health services that are high quality, equitable, and approachable. One approach to achieving these standards is to thoroughly explore the range of definitions, thoughts, and feelings held by African American women relative to mental health care in general and in relation to themselves with a focus on clarifying the deterrents and motivations for seeking out formal care. This approach is based on the premise that significant to service utilization are the subjective beliefs regarding the suitability and adequacy of practices. Accordingly, exploration in this area serves to inform providers of the populations' perceptions of "goodness of fit" through the words of past and potential consumers. It is imperative that the mental health establishment as a whole and practitioners specifically become

aware of factors affecting professional help-seeking attitudes so as to develop strategies geared toward the cultural characteristics of the population thus facilitating adaptive help-seeking from mental health care providers.

Research Questions

The present project is designed to address the following research questions through semi-structured interviews:

a. What is the range of definitions, thoughts, feelings, and views held by African American women relative to professional mental health treatment?
b. What are the perceived barriers and incentives to seeking out formal mental health care?
c. What are the kinds of problems that African American women consider appropriate for this form of help?

Purpose of the Study

The purpose of this study was to explore and broadly describe issues significant to patterns of professional mental health care utilization among African American women. Insights gained through the voices of African American women through the use of qualitative methodology provides important information about their understanding of and attitudes toward the use of formal mental health services and the influence of these attitudes on their initial willingness or reluctance to seek treatment. To determine and articulate the influences and

internal processes motivating or hindering African American women from utilizing formal mental health care may provide a means for the design of outreach and interventions strategies that target those influences and processes.

Significance of the Study

According to Caldwell (2003), the mental health establishment must continue to work adamantly toward attaining equality among the races in access and in use of mental health services, particularly with respect to African American women. For instance, because African American women tend to exhibit high rates of certain psychologically based health problems, such as hypertension and alcohol use (Landrine & Klonoff, 1996), it becomes more and more important for mental health care providers to become well-informed in order to link this population to much needed care. To further movement in this area, this investigation expands and clarifies our understanding of issues significant to the attitudes of African American women toward professional psychological care as they affect patterns of service utilization. Insights gained in this area will provide psychologists and other mental health care professionals with an understanding of the social and cultural norms and beliefs of African American women and their affect on the willingness or reluctance to seek the help of mental health professionals. The study will strengthen mental health care providers' ability to address overlooked or less addressed issues related to the development of innovative and timely methods that will connect those in need of treatment to service providers. In doing so, the system will more effectively be able to bring

about changes that will subsequently increase the likelihood of seeking out professional care (Vogel & Wester, 2003). Qualitative methods of inquiry were chosen as these methods allow for the exploration of the full experiences of participants from their own vantage point and in their own words.

Design of the Dissertation

This dissertation has been organized into five chapters. Chapter 1 provides a brief introduction to the problem, along with the study's research questions. Chapter II consists of the review of the literature that provided an appropriate background for the research. Chapter III explains the research design, methodology, data analysis, and provides a brief introduction to each participant. Chapter IV focuses on the results and the meanings derived from the analysis, while Chapter V consists of the discussion, recommendations, implications for future research and practice, and conclusions.

CHAPTER II

Review of the Literature

> Well son, I'll tell you: life for me ain't been no crystal stair.
>
> Langston Hughes (1926, p. 67)

African American Women and Mental Health

African American women face a diversity of mental health issues and concerns as they are continuously attacked and confronted day after day due to their racial, historical (involuntary immigration), cultural, and economic position in American society (Taylor, 1999; Chisholm, 1996; Matthews & Hughes, 2001). The dominance of race, gender, and social class shapes the reality in which African American women experience and thus maneuver throughout their lives (Brown, 2003). Societal factors have proven to be the most salient influences on the mental health and well being of African American women, despite medical science endeavors seeking to identify biological and genetic determinants of mental health and illness (Brown, 2003). As targets of both racial and gender stigma, they therefore are at "triple jeopardy." They not only must contend [with] the individual effects of racism and sexism and the discrimination emanating from the two in isolation, yet they are also required to navigate the sequelae of interactional effects as well. This circumstance differs from the experience of African American men, for whom racial victimization is most important, and European American women, where gender victimization is most significant (Comas-Diaz & Greene, 1994). These constraints render African American

women vulnerable to the concurrent effects of racism and sexism in ways that no other race and gender subgroup of the U.S. population suffer (Brown, 2003).

Ethnic group membership modifies the limitations in which African American women are permitted to function as women, such that while there are common experiences shared by African American and European American women, for example, there are sizable differences as well (Smith, 1981; 1985; Chisholm, 1996). Differences exist in the occurrence of chronic life conditions such as racism, race-based residential segregation, poverty, inadequate housing, unemployment and/or decreased access to employment, single parenthood, crime, poor quality goods, food (Lott & Bullock, 2001; Schulz et al., 2000), and services, and fewer resources such as quality and equitable education. The collective effects of exposure to the multiplicity of pervasive and severe stressors in which African American women face have been hypothesized to contribute to the more rapid deterioration in the health of these women when compared to European American women. This effect is known as the "weathering hypothesis" (Geronimus, 1992). Case in point, Taylor, Henderson, and Jackson (1991) identified life stress, physical health problems, and internalized racism as significant predictors of depressive symptoms in African Americans. Further, Link and Dohrenwend (1980) and Williams (2000) theorize that health problems may be antecedent to a sense of [demoralization], thereby increasing the risk of developing clinical depression in women who are already predisposed to developing psychological distress due to psychosocial and environmental and economic stress. Conversely, though there are increasing numbers of African

American women entering and completing four-year college and graduate programs, many describe feeling detached and alienated from support (Greene, 1994). These women find themselves becoming the first African American woman to hold a significant administrative position (Brown, Parker-Dominguez, & Sorey, 2000). In addition, they describe receiving subtle messages that they are inferior or that they were hired or admitted on the basis of affirmative action. These women may be deemed the beneficiary of affirmative action (Boyd-Franklin, 1987) and thus their competency may be questioned (Brown et al., 2000). Such "messages are extremely demeaning and can destroy the spirit and sense of self" (Boyd-Franklin, 1987, p. 395). As a consequence, many question their own abilities (imposter) working to increase and or facilitate anxiety and depression, among other conditions (Brown et al., 2000). African American women do find common ground with their African American male counterparts who also experience restrictions in freedom based on race, yet racism is experienced qualitatively different relative to discrimination based on gender (Chisholm, 1996).

As such, services providing relief, skills, and techniques essential for managing and negotiating the anguish and dejection ensued by African American women and their "triple jeopardy" status is crucial. African American women must have a "safe space" to allow them to freely voice their thoughts and feelings on such topics as racism, discrimination, sexism, issues of skin color and body perception, spirituality, alienation, cultural identity, relationships, and other issues (Boyd-Franklin, 1991; Collins, 2000). These women must be able to work

comfortably within a therapeutic context such that they are able to acknowledge the destructive effects of sexism, racism, and elitism, deal with negative feelings imposed by their status in society, clarify their role in obtaining solutions to their problems, understand the interplay between the environment and their inner environment, and recognize opportunities to change the responses from the wider society (Espin, 1993). Skills that will combat self-hatred and shield African American women from negative cultural beliefs, uncover internalized racism and sexism, and enhance self-power, are vital (Smith, 1981; 1985). Yet to provide such services, African American women must first contemplate the mental health system as an option of care during psychological distress.

Help-Seeking and Service Utilization Among African American Women

African American women experience high levels of financial and psychological distress due to their historical backgrounds, higher health risks, and numerous role strains (Caldwell, 1996). In response to these conditions, African American women employ various coping strategies to overcome their difficulties. One coping strategy, help-seeking behavior, is defined as any communication to friends, family member, ministers, and/or the like regarding a problem or difficulty directed toward obtaining support, advice, or assistance in instances of distress (Vogel & Stephen, 2003). According to Sussman, Robins, and Earls (1987), there are specific stages through which individuals progress prior to seeking out professional mental health care. First, these individuals must recognize their feelings or symptoms as indicative of a psychological disorder.

Second, one must assess their problem to be unusual and severe enough to require treatment. Finally, this awareness motivates individuals to seek out counseling or therapy. The decision to seek out professional care can be related to characteristics of the individual, characteristics of the symptoms, and/or attitudes and beliefs about the etiology of and treatment recommendations for psychological problems (Corbett, 1998).

One form of help, the use of mental health services is a mode of assistance rarely relied upon as a means of addressing psychological and emotional distress. Many studies have reported the underutilization of specialty mental health services for psychiatric symptoms and disorders by all Americans, however, the disparity between need and use was greatest for African Americans and Latinos (Gallo, Marino, Ford, & Anthony, 1995; Sue et al., 1991). These circumstances seem paradoxical given the circumstances that occupy these groups. In fact, according to Kessler (1979), "socially disadvantaged persons will be both more highly exposed to stressful experiences and also more highly influenced by stressful experiences than socially advantaged persons" (p. 259). In this same study, the researcher found that persons of color are twice as likely to report "extreme distress" as a function of experiencing more stressful situations. Minority status, in and of itself, is a risk factor for both mental and physical health problems.

Prior to seeking out psychological care, many African American women look to family members, friends, neighbors, coworkers, the church, and other members of their communities, and social networks for assistance in defining and

identifying solutions to their problems (Neighbors, 1984; Caldwell, 2003). The church in particular has provided a means for survival in the African American community by functioning as a source of strength and solace in a hostile America (Lincoln & Chatters, 2003). One of the most consistent findings regarding African American religious involvement is that African American women are more likely than their male counterparts to engage in and support a variety of religious behaviors, attitudes, and beliefs (Lincoln & Chatters, 2003). Although ministers tend to have little mental health training, a greater number of African American women consult ministers as opposed to other resources in instances of psychological distress (Lincoln & Chatters, 2003). While counseling provided by ministers is a traditional benefit of church membership, the adequacy of training that ministers have received to address serious mental health concerns has been called into question (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). In comparing the level of severity of problems that are brought to ministers to that of those taken to mental health professionals, empirical investigation indicates that both type and severity of symptoms are similar (Neighbors, Musick, & Williams, 1998). Yet, regardless of their preparation or training, ministers are consistently faced with having to assist African Americans, especially African American women, with such problems (Neighbors et al., 1998). In light of these circumstances, the church then has many significant implications (Richardson & June, 1997), providing the appropriate foundation for needed care to take place. Accordingly, Richardson and June assert that it is important for mental health care professionals to develop partnerships with ministers and other church

leaders to provide opportunities for counselors and/or therapists to become active agents in assisting with the promotion of the mental health and well being of parishioners through both prevention and treatment, when necessary (Richardson & June, 1997). Gaining the support of ministers and other leaders will provide mental health professionals with

> access to a referral system that can enhance the relationship between counselor and client. A person is more likely to participate in counseling and feel more comfortable with a counselor who has the respect and trust of his or her pastor and church community (Richardson & June, 1997, p. 160).

According to Caldwell (1996), women who perceive their family system and/or social network as close may rely on members to assist in discerning whether their presenting concerns are truly indicative of a problem, the severity of the problem, the amount of distress caused by the problem, and whether professional intervention is necessary. Hence, the use of professional resources may often either be facilitated or hindered depending upon the specific helper contacted for guidance (Caldwell, 1996). Once and if an issue has been identified as a problem worthy of professional help, despite the severity of the presenting complaint/s, African Americans typically opt to avoid the use of formal psychological care even when serious mental health problems are evident (Taylor, 1999). For instance, phobia is reported to be the most frequently occurring anxiety disorder among African American women (Robins et al., 1981; Ziedonis, Rayford, Bryant, & Rounsaville, 1994). The disorder can be chronic and

is likely to be comorbid with other psychiatric disorders such as depression. Still, fewer than 25 % of those experiencing symptoms indicative of a phobic disorder ever go on to receive treatment and of those who do, many are unlikely to receive culturally relevant care as African Americans may exhibit symptoms that differ from those of their European American counterparts (Neal & Turner, 1991; Brown, Abe-Kim, Barrio, 2003). These circumstances in turn continue to foster a basic mistrust in the capacity of mental health care professionals to provide culturally appropriate psychological treatment. As the majority of service providers are European American with middle-class values and orientations (Comas-Diaz, 1992), services rendered may not be perceived as desirable or useful (Wallen, 1992). Morris (2001) notes:

> Because traditional clinical therapy and practice are grounded in Western assumptions, there is a high probability that many clinicians and diagnosticians are "operating in the dark" when working with African American clients. Because of limited cultural information, there is the potential for service providers to make faulty assumptions, inaccurate diagnoses, incongruous treatment plans, and inappropriate assessment protocols" (p. 566).

Given these circumstances, the mistrust in the mental health system that African Americans and other underrepresented or misrepresented groups exhibit is far from unfounded. In instances in which the use of professional psychological services does take place, it tends to be limited to the use of primary care physicians (Whaley, 1998; Brown et al., 2003). When describing their symptoms,

African Americans are more inclined to report somatic complaints than are European Americans, which may impact decisions regarding where to seek treatment (i.e., primary care vs. mental health settings) (Brown et al., 2003). Additionally, this greater emphasis on somatic symptoms and physical functioning may contribute to lower detection of psychological distress, as physicians' recognition is higher when patients report psychological distress and impaired functioning (Coyne, Schwenk, & Fechner-Bates, 1995).

African American women with higher levels of education are typically more likely to use both informal and professional resources than women with less education (Caldwell, 1996). One explanation offered for this relationship is that women with higher levels of education have greater access to professional services than women with less education (Neighbors, Caldwell, Thompson, & Jackson, 1994), due to their higher economic standing and thus availability of resources. However, research suggests that race differences in mental health service utilization exist still among insured populations (Padgett, Patrick, Burns, & Schlesinger, 1994), suggesting that even with more economically stable individuals, service utilization is by far less than what might be expected despite evidence of distress. Some speculate that variables other than lower socioeconomic status or insurance coverage may better explain observed differences among African American women (Padgett et al., 1994).

The decision to seek mental health services is often viewed as inconsistent with traditional coping styles. In its place, African American women choose informal systems for needed support or they make attempts to take care

of the problem on their own (Mays & Comas-Diaz, 1988). "Admitting an intrapsychic problem that cannot be solved by oneself or with informal help is often not consistent with images of how ethnically identified Blacks cope with problems" (Mays et al., 1996, p. 163). In the case of African American women, to be self-reliant is tantamount with the role of being an African American woman (Mays & Comas-Diaz, 1988).

CHAPTER III

Method

> Not everything that can be counted counts, and not everything that counts can be counted.
>
> Albert Einstein (1879 - 1955)

The purpose of this study was to explore and to broadly describe issues significant to patterns of professional mental health care utilization among African American women. I chose a qualitative design as these methods of inquiry allow for the exploration of the full experiences of participants from their own points of view and in their own words. Qualitative methods can be used to add new information in areas in which little is known but may also be used to gain new perspectives in areas in which much is already known and may serve to provide more in-depth information that may be difficult to convey quantitatively (Marshall & Rossman, 1999). The advantage of this methodology is that it provides the answers to "why" and "how" questions, while additionally providing clarity as to "what it is like" (Wilson, 1989). Insights gained through the voices of African American women will provide pertinent information regarding the subjective beliefs and attitudes toward counseling and/or therapy as a source of help in instances of personal and emotional distress. Marshall and Rossman (1999) noted that:

> One cannot understand human actions without understanding the meaning that participants attribute to those actions – their thoughts, feelings, beliefs, values, and assumptive worlds; the researcher, therefore,

needs to understand the deeper perspectives captured thorough face-to-face interaction (p. 57).

I sought to explore the range of perceptions held by African American women relative to counseling or therapy with a particular emphasis on exploring the perceived barriers and incentives to seeking care that affect initial decisions and willingness to receive treatment. Linked with the abovementioned is exploration dedicated to identifying the circumstances, if any, in which counseling or therapy may be perceived as an appropriate form of help in times of personal and emotional distress. These objectives are based on the premise that significant to service utilization are assumptions regarding the suitability and adequacy of practices.

Research Design

This investigation relied upon qualitative methods of data collection and analysis. A qualitative design was most appropriate for this study as the objective was to elicit participants' own perspectives as described from their own points of view in their own words. According to Denzin and Lincoln (1994),

> The word qualitative implies an emphasis on processes and meanings that are not rigorously examined or measured (if measured at all), in terms of quantity, amount, intensity, or frequency. Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry ... In contrast, quantitative studies emphasize the

> measurement and analysis of causal relationships between variables, not processes. Inquiry is purported to be within a value-free framework (p. 4).

Quantitative researchers carefully design all aspects of a study before actually collecting data (Ary, Jacobs, & Razavieh, 1996). They identify variables, measures for those variables, statistics appropriate for analysis of the data, etc. This is possible as quantitative researchers know in advance exactly what they are seeking to find (Ary et al, 1996). Quantitative researchers are able to conceive of what a test of their hypotheses or answers to the questions might look like. Yet qualitative inquirers seldom, if ever, totally specify all aspects of the design prior to beginning the study as the design emerges as the study unfolds (Ary et al., 1996). A qualitative design allows for adjustments to the methodology and design to remain consistent with the phenomena under study. This process is necessary as the qualitative researcher is never entirely knowledgeable of what will be learned, given that what will ultimately be learned is dependent upon the nature and type of interactions between the researcher and respondents (Ary et al., 1996). Lastly, significant features in need of investigation cannot always be known until they are actually witnessed by the researcher (Ary et al., 1996).

The individual interview was selected as the method of data collection as it allows for the identification and exploration of participants' range of beliefs, experiences, and behaviors expeditiously (Weiss, 1994). According to Bogdan and Biklen (1998), " . . . the interview is used to gather descriptive data in the subjects' own words so that the researcher can develop insights on how subjects interpret some piece of the world" (p. 94). One way of defining interviews is

based on the amount of structure, which is typically defined along a continuum from highly structured to semi-structured to unstructured (Merriam, 1998; Bogden & Biklen, 1998). In this study, the objective was not for the format of the interview to be so rigid that respondents were unable to tell their stories in their own words. My intention, however, was to obtain comparable data across respondents, thus a certain degree of structure was necessary (Bogden & Biklen, 1998). As such, I elected to utilize the semi-structured format, which according to Wilson (1989), "the intent of the semi-structured interview is to get at the subject's perception of the meaning in his or her world without introducing the investigator's conception of it" (p. 383). This method allows the researcher to maintain control over the flow of conversation yet fosters a diversity of ideas and questions to be addressed during the course of the interview (Bogden & Biklen, 1998). The interviews lasted from 1 – 1 ½ hours, depending on the amount of information that the participant was able or willing to share.

Participants

The purpose of qualitative research is not to answer questions of frequency and quantity, yet to describe and explain (Marshall & Rossman, 1999). For that reason, a nonprobability sample (sampling through other than random sampling) was most appropriate. Purposeful sampling (Merriam, 1998) was done in which participants were chosen based on attributes that would yield the most meaningful information. LeCompte and Preissle (1993) indicate that this process of selection involves creating a list of participant characteristics and subsequently locating persons who meet these characteristics. For the objectives of this study,

the participants were required to be African American, female, and at least 18 years of age. Additional demographic information was sought to ensure some diversity among the participants. I solicited the assistance of African American women on my job that might be able to assist in identifying other self-identified African American women age 18 and older. Through these connections, I was able to identify a pool of potential participants. Interested parties were subsequently contacted by phone, consented, and screened to ensure that the minimum selection criteria were met. Those meeting the predetermined standards were invited to participate in one 90-minute individual interview and to complete 1 demographic questionnaire. In addition, each participant was informed that following the interview, once transcribed, the transcription would be sent to them directly to review and/or make changes to the transcriptions in order to confirm the accuracy of the data (Lincoln & Guba, 1985). Once the transcript has been analyzed, my interpretations will be sent back to each respondent so that they are able to comment on any errors of fact and to note any error in interpretation of their responses.

Apparatus

The interviews were recorded using a Panasonic RQ2102 standard-size cassette tape recorder. The recorder had a 3-digit tape counter, a 3" dynamic speaker, and a built-in condenser microphone. The interviews were recorded on 120 minute Maxwell UR Normal Bias Audio Cassettes for dictation and portables cassette players.

Measures

Telephone Screening Questionnaire. During the initial interview by phone, interested parties were asked, once consented (Appendix A), to respond to questions relative to their self-identified ethnic identity and age. Participants were also asked questions about their partner status, current living/residential status, who lives with them, income bracket, highest education level reached, and current occupation (Appendix B).

Demographic Questionnaire. Demographic information was collected from all participants. This data was gathered by asking respondents to directly enter requested information or to endorse the category that is most descriptive of their age, current dating/marital status, persons living with the respondent at the time of the interview, current living/residential status, socioeconomic bracket, income bracket, highest educational level achieved, employment status, and a description of their current occupation. In addition, interviewees were asked to indicate both parent's highest level of education, their parent's current or most recent occupation, description of childhood family makeup (those living in the home), childhood/current religious affiliation, description of childhood home and neighborhood, and percentage of childhood/current African American friends (Appendix E).

Interview Guide. To ensure that all participants were provided with similar opportunities to address certain topic areas and to make certain that I addressed each of the subtopic areas at some point during the interview, a semi-structured interview guide was developed to provide a general structure. The protocol was

reviewed and edited by 2 psychologists, 1 psychiatrist, and an educational administration professor proficient in qualitative methodology (Appendix C).

Procedures

I solicited the assistance of African American female colleagues that would be able to recommend other self-identified African American women for participation in the study. Through these contacts, I was able to identify a pool of potential participants. Interested parties were subsequently contacted by phone, consented (Appendix A), and screened (Appendix B) to ensure that each respondent met the minimum selection criteria. In the sample, I made every attempt to gain diversity in terms of marital status, level of education and most recent occupation, parent's level of education and most recent occupation, childhood and current family makeup, childhood and current religious affiliation, community, % of childhood and current African American friends, current living/residential status and income bracket, etc. The nature of the study was explained and each potential interviewee was asked if clarification was needed on any part of the study that was to be conducted. Those meeting the predetermined criteria were invited complete a demographic questionnaire (Appendix E) and to participate in one 90-minute individual interview (Appendix F). Together, the participants and I scheduled a time and day to meet. Each participant was informed that the interview would be audio-recorded yet that her confidentiality was guaranteed to the maximum extent of the law. They were informed that following the interview, once transcribed, the transcription would be sent to them directly to review and/or make changes to the transcriptions in order

to confirm the accuracy of the data (Lincoln & Guba, 1985). Participants were informed that once the transcript has been analyzed, my interpretations will be sent back to the respondent so that they are able to comment on any errors of fact and to note any error in interpretation of their responses. Participants were reassured that they would not be required to respond to any questions which made them uncomfortable and that not responding would have no ramifications.

Each participant received an interview confirmation letter (Appendix C) confirming our telephone conversation, the purpose of the study, what will be asked of the participant on the day of the interview and following the interview, and each participant was reminded that the interview will be audio-recorded, yet confidential (Willig, 2001). Participants were informed of the use of pseudonyms in the presentation of all data to insure confidentiality. Each participant was reminded that the University Committee on Research Involving Human Subjects and the Department of Counseling, Educational Psychology, and Special Education at Michigan State University approved the project. They were also reminded in the letter, as discussed per the telephone conversation that once the interview has been transcribed, the transcribed interview will be sent back to the respondent to review and/or make changes to the transcriptions to confirm the accuracy of the data. In addition, once the transcript has been analyzed, my interpretations will be sent back to each respondent so that they are able to comment on any errors of fact and to note any error in interpretation of their responses. Participants were asked to reserve 90 minutes for the interview and

were reminded of the scheduled interview date, time, and place. The day prior to the interview, each participant received a reminder phone call.

The interviews took place at the convenience of the participant at a location of her choice in which case, all were conducted in the respondents' homes. On the dates scheduled for participation, each participant and I went over the informed consent form (Appendix D), the form was signed, and all participants were permitted to ask questions. Each respondent was reminded of the purpose of the study, that their participation was strictly voluntary and confidential to the maximum extent allowable by law, and that they were free to withdraw from the study without any penalty at any time. Participants were reassured that they would not be identified by name on any tapes or transcripts. Instead, each participant was assigned a three-digit research ID number that was used for these purposes on all obtained materials. Participants were also reminded that their names would not be associated with any reported or published findings emanating from the project and that pseudonyms would be used for the presentation of data.

After responding to questions regarding participation, etc., I attempted to make small talk with each participant in an effort to begin establishing a rapport that would in the end prove to be beneficial in that the more comfortable the respondents were, the more inclined they were to provide thorough responses. I then conducted the audio-recorded interviews using a standard-size cassette tape recorder.

All interviews were transcribed and the data were analyzed, as they were collected. The completed transcripts ranged in length from 8 to 22 single-spaced pages. The transcripts were prepared in a double-spaced format with line numbers to assist with analysis. Immediately, at the end of each interview, I recorded my observations of participants' appearance (i.e., apparent age, build/weight, attire), behavior (i.e., distant, indifferent, depressive, anxious, sullen, lethargic, alert), motor activity (i.e., awkward, mannerisms, gestures, picking on body, relaxed, restless) interpersonal style, and facial expressions (i.e., relaxed, day-dreamy, tense, happy, sad, alert, smiling). I also made note of the participants' characteristics of speech (i.e., normal, articulate, loud, accent, amount), mood and affect, perceived intellectual ability (i.e., above average, average, below average), organization of thought, and insights, etc. I included summaries of what I did and how I thought and felt during the process, my reaction to the interviews in general, my responses in certain instances, comments on what I felt about arising new issues, and any possible edits to interview questions. In addition, I made note of passing thoughts, questions for further research and resolution, biases, and challenges to myself in process notes (Glaser & Strauss, 1967; Strauss & Corbin, 1990). The intention of these notes was to identify what I was learning, to speculate on possible themes, to plan future directions for the project, and to discuss mistakes and misunderstandings (Bogden & Biklen, 1998). This information provided background information and context for interpreting the interview transcripts

during analysis; thus an additional source of information ensured the trustworthiness of the data and analysis (Lincoln & Guba, 1985).

The data was collected over a 6-month period until I reached saturation or once the data became redundant with that which was previously collected (Glaser & Straus, 1967; Merriam, 1998). In this study, I recognized that I attained saturation once I was able to predict how respondents would respond to each question during the interview process and when the data collected was similar to that which was previously collected in preceding interviews. The final sample size consisted of 8 African American women ranging in age from 21 – 55 years of age with a mean age of 31.8. A description of each respondent is presented in the following paragraphs using pseudonyms.

Janet is a 30-year-old African American woman born and raised in a large city on the East Coast and is the youngest of 3 children born in an intact marriage. Her brothers are 37 and 34 years of age. She expressed that both are successful businessmen and are both married with children. Her parents have been married for 39 years and are both retired schoolteachers. Janet stated that her family was never "religious, even though both my parents were raised Baptist . . . now, I've sort of put that on the backburner . . . I haven't figured it all out; what feels right for me." She expressed that her relationships with her family members have "always been positive . . . I've always been closest to my mother, but we all love and trust each other tremendously." Janet is presently a doctoral student at a private university and holds a ½ time teaching assistantship in which she is required to teach 20 hours per week. She is to graduate in May and will be

marrying her fiancé in August. The two have been together for 3 years and have lived in the same 2-bedroom apartment for 1 year. Janet has always attended predominantly European American universities, yet aspires to teach undergraduate level courses at a Historically Black College or University (HBCU). She has never had counseling or therapy.

Hazel is a 42-year-old African American woman from a large city on the East Coast and is the eldest of 4 children born in an intact marriage of 43 years. Her father is a retired professor and her mother is a retired elementary school principal. Her youngest sister, aged 30, is a doctoral student, her 35-year-old sister is a drama teacher, and her brother is a 38-year-old physician. Hazel stated that she is close to her family and feels "very supported by them." She is currently residing with her parents at her childhood home with her 3 children, ages 4, 9, and 16. She stated that since moving home, she feels "a lot like a little girl when it comes to my mother . . . she has always had a sharp tongue . . . I find myself doing things to appease her." She stated that although she was raised in a Catholic home, she is now Baptist. Prior to moving in with her parents, she lived in a small city on the East Coast with her husband of 11 years who is a pediatrician in private practice. Hazel asserted that she and her husband have been having "marital problems, which we're working on." She expressed that she realizes that her husband "makes decisions that are only going to best serve his own happiness . . . I got tired of being unhappy, isolated, and feeling miserable in that small city . . . he wasn't making any changes and he was beating around the bush so I decided to push the issue a little and I moved my kids and I moved

back home." She was married approximately "a year or two right out of undergrad," and remained married for 10 months. From this union was born her eldest daughter, now 16 years of age. Following her divorce, she went to law-school. She stated that upon having her second child, she became a "stay at home mom." At present, she is working part-time and looking for a full time position as a labor relations attorney. Hazel expressed that she has "gone in and out of depression for as long as I can remember . . . I was on medication for six years but I'm not currently on any medication and not seeing a therapist."

Kimberly is a 55-year-old African American woman born and raised in a large city in the South. She is the eldest of a female sib ship of two born in an intact marriage, though she states that "my parents just lived in the same house . . . no one was ever willing to give up the house . . . mom lived upstairs while dad lived downstairs." Her father, now deceased, was a roofer while her mother was a seamstress, also now deceased. Her 49-year-old sister is a "house wife." She stated that she

> always had a good relationship with my father but my mother was always cruel to me . . . looking back, I realize that she was jealous of my relationship with my father. My baby sister was always passive and did what ever she could to keep things calm in the house . . . now she's just like my mother to her child.

Kimberly stated that she has always had a "conflictual" relationship with her sister. They rarely speak though they live in the same city. She asserted that she does not understand why the two have always been "at odds . . . it's like she

wants to continue my mother's vendetta against me." She asserted that she was "born and raised in a Lutheran Church." She expressed that as a result of her "religious upbringing and relationship with God," she has been a consistent member of a church. Kimberly received a BA in accounting from a small HBCU in the south in 1971. She married her "high school sweetheart," however; the two divorced after six years of marriage. Two years later, she married a longstanding friend of 13 years. Together, the two have a daughter, now 27 and a son, now 24. Her daughter is a lawyer in a large Midwestern city and her son lives at home and is a physical trainer at a local fitness center. Kimberly works for a small independent accounting firm while her husband is a real estate broker. She expressed that her marriage is much like her parent's marriage, elaborating by stating that she and her husband rarely talk. She remains in her bedroom at night until awaking the next morning for work while her husband remains in the living room "drinking beer and vodka until 11:30 or 12 am." Kimberly stated that she loves her husband but that they are unable to "meet." She expressed that she has never been to counseling and has no intentions of do so.

Michelle is a 26-year-old African American woman born and raised in a large city on the East Coast. She is the youngest of 4 [four] children born to her mother including two sisters and one brother. She stated that each of her mother's children has a different biological father and that she is unsure of her father's identity or his whereabouts. Her mother received some high school yet never earned her diploma. She expressed that her relationship with her mother "is much better." She elaborated by stating that her mother was consistently in

and out of emotionally and physically abusive relationships. Michelle described numerous instances in which she witnessed her mother's abuse. She expressed that her mother was an alcoholic and recalls, as the youngest and only child still at home, "many times where I had to literally pick my mom up off the ground down the street from our house . . . I was eight or nine years old." Michelle stated that she often went to school "hungry and dirty" as her mother was unable to care for her adequately. She reported, "We finally found out that my mom is Bipolar." Michelle stated that since her diagnosis, her mother has "tried to stay consistent with her medication and over the years she has been in therapy." Michelle was recently married to her partner of three years. She expressed that the two met in college. She stated that her two sisters were scheduled to be bridesmaids in the wedding; however, both neglected to show or call. She stated that she has not seen her brother in about "three years." Michelle is a public school music teacher and her husband is a public high school guidance counselor. Her husband is "a preacher's son," stating that as a result of her relationship with her now husband, she has "become closer to God," and is now an active member of a Baptist church. Michelle reported that there have been a few "transitional problems" between the two, yet that they are "ok."

Joyce is a 37-year-old African American woman born and raised in a large city on the East Coast. Joyce is the youngest of a sib ship of six. Her parents were married and divorced; however, both are deceased due to her mother's colon cancer and her father's lung cancer. Her father was a salesman and her mother was a seamstress. Joyce and her two elder brothers, ages 38 and 39

have the same biological father, however, her 44 and 46-year-old sisters, and 48-year-old brother are from her mother's first marriage. She expressed that she never had a "positive relationship" with her mother, yet felt close to her father who moved to the South and remarried when she was a teen. She expressed that during that time, she felt closer to her stepmother than her biological mother. Joyce expressed that her biological mother always degraded her father and she for being her father's child (e.g., "you're worthless just like your father, "you're never going to turn out to not be worth nothin' like your father"). She is the mother of three, including a 21 and 12-year-old daughters and a 9-year-old son each with a different biological father. She has never been married though she and her 12 and nine year old currently live with her "common-law husband" of five years in a two bedroom apartment. Joyce asserted that her children refer to this man as "daddy." She expressed that he has always treated them as if they were "his own." Joyce is a nurse's assistant in a geriatric center and received her GED after "getting clean off of heroin." Joyce asserted that while on heroin, her youngest children were taken by the state and placed in a foster home. Three years ago, her children were reunited with their mother. Joyce expressed that she has never been a "holliroller" although she was brought up to be Catholic.

Robin is a 22-year-old single African American woman born and raised in a large city on the East coast. She is the youngest of four children born to her mother. Robin has two brothers, ages 23 and 11, and a sister age 10. The 11 and 10-year-old children are the result of her mother's second marriage, though they are now divorced. The two children currently live with their father and visit

their mother on holidays and during the summer break. Her parents were married until her father "past away." Her father was an entrepreneur (oil company/trucking) while her mother is currently a student, an entrepreneur, and a postal employee. Robin expressed that she has always had a very close relationship with her mother, while her father worked a lot and was merely a "provider." She stated that she does stay in touch with her older brother though she rarely sees him as he now lives in a in a large Midwestern city. Robin reported that as an undergraduate, she finally saw a therapist at her university counseling service after suffering from "deep depression" for six years. She was finally diagnosed at age 20. Robin reported that since that time, she has become more "spiritual." She asserted that as a child, her family was Baptist. Although she attended undergraduate school, she did not earn a degree. At present, she describes herself as an entrepreneur. Specifically, her mother owns a building in which Robin rents two commercial spaces for her natural hair salon and a vintage clothing store. She is not presently in a relationship, although she describes meeting her "soul mate" two years ago who she maintains a "spiritual connection" with.

Jessica is a 21-year-old single African American woman from a large City on the East Coast. She is the eldest of three children including her 19-year-old sister and 14-year-old brother. Her parents were divorced when she was seven years of age. Since that time, her father has had little contact with his children except for "collect calls on our birthdays." As a result, Jessica asserts that she had had little to do with her father and over the past two years, has refused to

speak to him. She expressed that her father continues to hold "this delusion that he was always there for us even though he wasn't with my mom and that's just not true. I'm tired of playing games with him and if he can't apologize or even admit to not being around, I don't have any need for a false relationship with him." Her relationship with her mother, however, has been close. She expressed that her mother was single until five years ago. Jessica stated that her mother is "strong and did an excellent job of working to take care of three children on her own." As a result of her mother's marriage, Jessica has gained a 13-year-old stepbrother. She recently moved out of her mother and stepfather's home to live with "two of my best girlfriends." Jessica stated that her mother's remarriage was "difficult . . . I didn't know how I felt about a man being in the house and everything." She stated that her relationships with her siblings are close, though she expressed that her sister's "episodes" have caused some riffs in their relationship. She stated that her sister fell through the floor of her bedroom, hitting her head on a chair in the room below. Since the incident, her sister has had many problems with "acting out." She expressed that her sister saw a therapist for a short period of time. Jessica is currently a pre-school teacher at magnet school. She is currently enrolled in school, yet she has yet to earn her degree. She recently terminated a long-distance relationship with a man with four children. Jessica stated that her reasoning for "breaking up" was due to his inability to "be emotionally present." She was raised as a Jehovah's Witness although she is not presently active. Once she gets her life "on the right track," she will resume her religious practices.

Dina is a 23-year-old African American woman from a large city on the East Coast. She is the eldest of a sib ship of two including her 19-year-old sister born to her mother. She expressed that she grew up in a single parent household and that her parents were never married. She stated that her father was murdered when she was two years of age, though she is unsure of the information surrounding his death. Dina reported that her sister's father has been "my dad." Her sister's father, however, died of AIDS in 1993. Her sister's father was never married to their mother although he did marry and from this union, he and his wife had two sons. Dina asserted that although "technically" her sister's younger half-brothers are not related to her, she still considers them to be her brothers and remains close to them today. She reported that her relationship with her mother is "a good one." Dina, nevertheless, stated that she feels uncomfortable asking about her mother's history with her father. She expressed feeling "unsure" of her identity given that she has never had any contact with her father or his family. Although she feels that she can go to her mother about "anything," she continues to feel that her father's history is something that she is not "allowed" to speak about with her mother. Dina stated that she has a "close" relationship with her sister and feels supported by their closeness. She is scheduled to graduate in May of 2004 with her Bachelors degree, though she would like to continue her work as a Natural Hair Care Consultant/Technician and is currently working on obtaining her own salon. She asserted that she was raised as a Jehovah's Witness although she is not currently practicing and

remains open to other "directions of spiritually." She stated that she has never been in therapy.

Data Analysis

The interview data was analyzed using constant-comparative methods (Glaser & Strauss, 1967). This method of analysis allows for the organization of raw data into conceptual categories and the construction of major themes emerging through the process of comparison. To apply this approach, I used a multi-step process of breaking down and conceptualizing the raw data. The first step, once the interviews were transcribed, was to begin the coding process in which all specific significant experiences described by participants were identified and coded into concepts. A list of concepts for each transcribed interview was generated and a copy of their own transcribed interview was sent to the participants to make any additions or corrections.

Following the coding process, I then began to generate categories. I went back to the transcripts and the master list to look for relationships among the concepts. Those concepts that seemed to be related were grouped together to form categories. The list of categories was reviewed to rid the list of any duplication and to assure that each concept fit at least one category. In addition, I established whether each category characterized numerous concepts from a variety of participants or if there was saturation. Those categories that were exclusive to one particular participant were eliminated and concepts falling within that category were reassigned to other appropriate categories. A list of categories was then generated. I then began to determine connections or

relationships between the categories. This process leads to the integration of some categories and thus refinement and finally the emergence of themes explaining the phenomenon. Once the transcripts were analyzed, my interpretations were sent back to the each respondent so that they were able to make note of any errors of fact or interpretation.

Trustworthiness

Research is concerned with imparting valid and reliable knowledge in an ethical manner (Merriam, 1998). To refer to the overall quality of a piece of research, Lincoln and Guba (1985) use the term trustworthiness. In order for research to be meaningful, the results must be trustworthy. This trustworthiness (quality) is established through the research design and the way in which the data are collected, analyzed, and reported. According to Lincoln and Guba (1985), to assure one's audience that their findings are valuable and worth considering, traditionally, researchers have found it helpful to ask themselves four questions:

1. "Truth value": How can one establish confidence in the "truth" of the findings of a particular inquiry for the subjects (respondents) with which and the context in which the inquiry was carried out?
2. Applicability: How can one determine the extent to which the findings of a particular inquiry have applicability in other contexts or with other subjects (respondents)?
3. Consistency: How can one determine whether the findings of an inquiry would be repeated if the inquiry were replicated with

the same (or similar) subjects (respondents) in the same (or similar) context?

4. Neutrality: How can one establish the degree to which the findings of an inquiry are the subjects' and not the biases, motivations, interests, or perspectives of the inquirer? (p. 290)

Within the conventional paradigm (quantitative research), criteria that have evolved in response to the abovementioned questions are termed "internal validity," "external validity," "reliability," and "objectivity." Internal validity is defined as the extent to which observed differences on the dependent variable in an experiment are the result of the independent variable, not some uncontrollable extraneous variable or variables while external validity speaks to the extent to which the findings of a particular study can be generalized to other subjects, other settings, and/or other operational definitions of the variables (Ary et al., 1996). Reliability encompasses the extent to which a measure yields consistent results; the extent to which scores are free of random error (Ary et al., 1996), and lastly, objectivity refers to the obtaining of identical results by varying investigators (http://en.wikipedia.org/wiki/Qualitative_psychological_research). These conventional criteria, however, are inappropriate for establishing the "trustworthiness" of qualitative research (Lincoln & Guba, 1985). Thus, Lincoln and Guba (1985) propose four alternative constructs, 1) credibility, 2) transferability, 3) dependability, and 4) confirmability, which more appropriately reflect the assumptions of qualitative research. Marshall and Rossman (1999) articulate four questions based on the constructs articulated by Lincoln and Guba

(1985) that more appropriately speak to qualitative researcher. They are as follows:

1. How credible are the particular findings of the study?
2. How transferable and applicable are these findings to another setting or group of people?
3. How can we be reasonably sure that the findings would be replicated if the study were conducted with the same participants in the same context?
4. How can we be sure that the findings reflect the participants and the inquiry itself rather than a fabrication from the researcher's biases or prejudices? (p. 192)

Credibility

Qualitative research is not concerned with establishing cause and thus it is inappropriate to pursue truth-value (internal validity) by demonstrating that causes and their effects have been isolated (Eisenhart & Howe, 1992). Thus, credibility represents the ability of the researcher to demonstrate that her or his interpretations of data (the findings) are credible (Eisenhart & Howe, 1992). According to Eisenhart and Howe (1992), there are two parts to meeting this standard: first, conducting research in a way that increases the likelihood of respondent categories emerging as opposed to researcher categories dominating the findings and second, having respondents approve the researchers' analysis of the data. One way of meeting this standard was to conduct member checks (Lincoln & Guba, 1985) to provide respondents with an

opportunity to review and/or make changes to the transcriptions to confirm the accuracy of the data, in which case, all respondents sent their transcribed interviews with little, if any, changes. Once the interviews were analyzed, my interpretations were sent back to each respondent so that they were able to comment on any errors of fact or interpretation. In addition, I requested that a doctoral student of psychiatric epidemiology familiar with the literature and a colleague in marriage and family therapy proficient in qualitative methodology provide feedback on the emerging findings. Further, I supported my findings by incorporating an analysis of my notes. Again, these notes provided background information and context for interpreting the interview transcripts during analysis; thus an additional source of information ensured the trustworthiness of the data and analysis (Lincoln & Guba, 1985).

Transferability

Within the conventional paradigm, as stated in the aforementioned discussion, external validity refers to the extent to which the findings of a particular study can be generalized to other subjects, settings, and/or operational definitions of the variables (Ary et al., 1996). Qualitative researchers, however, are unable to make precise statements regarding the external validity (expressed, for instance through statistical confidence intervals) (Lincoln & Guba, 1985) of their findings, nor is the intention generalizability of the findings. "Whether they hold in some other context, or even in the same context at some other time, is an empirical issue, the resolution of which depends upon the degree of similarity between earlier and later contexts" (1985, p. 316). Qualitative

researchers are merely capable of providing a detailed description of the time and context of the investigation to enable readers to assess the similarities and differences of their situations and those described in a research project (Lincoln & Guba, 1985). I attempted to recruit a fairly diverse sample to assist in presenting the findings across range of perspectives (Merriam, 1988, 1998) and ensured that no two respondents were associated in any way.

Dependability

Reliability describes the possibility of repeating a study and obtaining similar findings. In quantitative research, reliability involves repeated measurements of the event or incident under study. Human behavior is not predictable and is ever changing. Thus, the possibility of replicating a study with the exact same findings within the social sciences is not likely. Merriam (1988) writes, "Clearly, replication of a qualitative investigation will not yield the same results (as it might in quantitative research). Rather, both sets of results stand as two interpretations of the phenomenon" (p. 56). Merriam (1998) posits that greater consistency between the findings and the data collected should be a primary goal in qualitative research. Guba and Lincoln (1985) propose dependability as the more appropriate standard. This criterion is concerned with attempting to account for changing conditions in the phenomenon chosen for investigation and changes in the design created by an increasingly refined understanding of the setting. To attain dependability, I developed an audit trail of materials that documented how the study was conducted; including what was done, when, and why (Ary et al., 1996). The audit trail included information about

participant selection, data collection and analysis, etc. (Merriam, 1995, 1998). Using the trail as a guide, my colleague from marriage and family therapy proficient in qualitative methodology examined the study to attest to the dependability of the procedures and to examine whether the findings were reasonably derived from the data (Lincoln & Guba, 1985).

Confirmability

Lastly, confirmability captures the traditional concept of objectivity. Lincoln and Guba (1985) ask whether the findings could be confirmed by another essentially focusing on whether the data assists in confirming the general findings and lead to the implications (Marshall & Rossman, 1999). To speak to confirmability, the audit trail, spoken of in the aforementioned discussion was used by my colleague to look at the raw data in the form of the transcribed interviews and my notes emanating from the process of the interviews, biases, etc., issues presenting themselves during the data collection process and actual data analysis process (coding, categories, construction of final/main categories, themes). This information provided background information and context for interpreting the interview transcripts during analysis; thus an additional source of information ensured the trustworthiness of the data and analysis (Lincoln & Guba, 1985).

CHAPTER IV

Results

> The voyage of discovery is not in seeking new landscapes but in having new eyes.
>
> Marcel Proust (1871 - 1922)

The purpose of this study was to explore and broadly describe issues significant to patterns of mental health care utilization among African American women. A qualitative research design allowed for the examination of the full experiences and perceptions of participants from their own point of view and in their own words through the use of a semi-structured interview format. The interview guide was designed to capture a broad range of definitions, thoughts, feelings, and attitudes held by the women toward professional mental health care in general and in relation to themselves to understand what generally motivates and/or deters African American women from seeking out professional help in instances of psychological distress. Questions were loosely organized to illicit participants' perceptions of barriers and incentives to seeking out counseling or therapy and the kinds of problems believed appropriate for professional mental health services.

An inductive analysis of the data revealed four themes including *It Doesn't Work, My Way Works Fine, No More Than I Can Bear,* and *Community Perceptions*. The first theme, *It Doesn't Work,* describes the subjective views of participants regarding professional psychological care. Within this theme, there were three sub-themes. They were "Therapy's Good But Not for Me," "It's Not Reasonable," and "Black Problems." The second theme, *My Way Works Fine*,

illustrates the manner in which these women go about promoting and preserving their psychological well being in opposition of making use of counseling or therapy in instances of psychological distress or in light of perceived non-benefit from past experiences with mental health services. Within the second theme, there were also three sub-themes. Specifically, they were "I Handle It On My Own," "Look Around You," and "My Circle." The third theme, *No More Than I Can Bear,* illustrates the women's articulations of the role of spirituality and religion in shaping their understanding of emotional and psychological distress and their faith as a way of "getting through." The fourth theme, *Community Perceptions*, describes respondents' observations of the general stance of the African American community and it's influence on their willingness to make counseling or therapy an option for assisting in attending to their problems and concerns.

It Doesn't Work

"Therapy's Good But Not for Me . . . "

When asked to provide a description of their understanding of and to form opinions about professional mental health care, the most frequently given response was that counseling or therapy is the process of speaking to a professional who is able to provide "objective advice." Due to professional training, this individual is capable of revealing or "pinpointing" information about one's circumstances that may not have been readily available. Getting to the "crux" of the issue provides one with a sense of relief or "letting go." Dina's articulation captured this in the following way:

> Well my understanding is that it's like talking to someone who can listen and who's objective and not just trying to push their opinions on you . . . someone who can give some good advice and give support in terms of helping to sort out what your feelings really are. It's probably like going to a friend but this person is a professional and can give you more objective input about what's like really going on. Maybe somebody who can help you go deeper than the surface and can give you that release that you really need. I haven't had a release in a while . . .

Though most respondents generally provided positive interpretations regardless of whether or not they themselves had ever had previous experience with mental health services, the majority of respondents believed or experienced mental health professionals to be of little assistance in addressing their concerns ("My experience from therapy has been that it doesn't work"). For one reason or another, most respondents maintained a "never have or never will (again)" attitude toward making use of professional psychological help as a means of attending to their personal and emotional distress. Many knew little of what the process actually looks like or how this form of help might truly be of any benefit. Those that did seem to have more of a knowledge base (informed by previous experience) regarding the utility of mental health services still felt that this type of assistance was inappropriate for future use. For example, Dina maintained a "not for me" position toward counseling or therapy in spite of what might be interpreted as a positive description.

"It's Not Reasonable"

Several women spoke of extreme cases in which one might consider making use of counseling or therapy and the fear of turning to an "expert" who is unable to provide the timely relief expected of a professional. Janet asserted,

> You just feel like if you did share that you wouldn't feel that you have really resolved anything immediately which is what you might have wanted . . . to feel much better right away. So you basically could have saved yourself the trouble and the money and asked a friend.

In addition to those without a prior history with counseling or therapy, those with previous experience spoke of entering therapy with the hope of receiving immediate relief in ways that would appear to both instantaneously and reasonably assuage their anguish. While in therapy, when the process was perceived as inconsistent with what should logically take place ("I tell you I have a problem and you ask me about my mom . . . I don't think therapy is supposed to be about hating your mom.") or help came in ways that validated preexisting and stereotyped fears of what counseling or therapy would provide (" I had to see this lady in undergrad and they tried to put me on some medicine and I was like man screw this"), those women tended to experience therapy as unhelpful in effectively addressing their needs and in most cases terminated treatment prematurely ("the 1st woman, I totally planned to work with her but I was just not motivated to go back to her at all. The 2nd therapist, I was like I'm wasting my time.") and vowed to never rely on this form of assistance for relief in the future.

Robin, who had prior experience with professional mental health care due to a history of clinical depression reported:

> hum . . . I thought it was crap. I was like man I'm not sick. She was trying to give me medication and tell me stuff that I didn't believe, like whatever . . . that's some crap. I use to tell her stuff and I would be thinking to myself, 'you don't know nothin' about me. Obviously you don't know nothin'. If you did, you would be trying to help me instead of giving me some pills like I'm sick or should be put in some hospital like I'm crazy.' I tell this woman I'm sad and she gone try and give me some pills like I'm crazy. I'm not crazy. I'm not sitting up here dribbling. I'm just sad as shit. You know?

For Robin, she was unsure of how counseling or therapy would be of assistance yet had preconceived notions of the type of care that was suitable and for what situations. Her unwillingness to adhere to the treatment recommendations of her mental health care provider was based on her understanding of what necessitates medication. She expressed, "I'm not sitting up here dribbling," alluding to her assumption that medication is intended for those with what she would characterize as severe mental illness and her own assessment of her condition as being far from severe and thus requiring medication. For Robin, her therapist's recommendations spoke to the therapist's incompetence and confirmed her views of mental health care services as wholly inconsistent with her treatment needs and generally those who are not severely disturbed/mentally ill. When asked whether she would ever make use of mental health services in the future, she responded:

> Heck no. I would rather be drunk everyday. I'll do better if I drink alcohol everyday. It does the same thing. Then they tell me chemical imbalance and, serotonin, etc. I'm sorry; I'm not taking no medicine. If I have to have sex everyday, all day, then that's what I will do. I'm not taking the medicine. So they were like ok.

"Black Problems"

A number of respondents articulated feeling that counseling or therapy seems incongruent with traditional African American cultural norms. In addition, many believed the mental health system to be unprepared nevertheless to address the concerns of African Americans (given the Eurocentric paradigm from which the system is based). Hazel who had previous counseling experience with a European American therapist asserted the following:

> I have had interracial therapy relationships (European American) and I found that culturally, they did not understand where I was coming from. They felt, the last person I went to, the first thing I said was "I'm really having problems with my husband. He won't help me with the kids, uhm, he's not doing the things he should be doing." The first thing out of her mouth was "Well, he's a pediatrician. Don't you think he would have been tired of working with kids because he works with kids all day and why didn't you discuss that with him before you two got married?" So, to me, I mean she had some pretty set preconceived notions about what I should have done . . . I had another White therapist . . . that same thing. She said "why do you let your father walk all over you?" I had said something about

> something that happened between me and my father and I don't know exactly what it was but she really offended me and I left that session feeling really offended and I came back and told her and she was like "oh really, huhm?" She just expected me to continue to work with her although I felt like she had so far missed the mark in terms of working with me through that situation and uhm I just really felt that there was a lack of knowledge about the Black family, about relationships between Black relationships and they were just not capable of helping me.

After having seen "a few" therapists (all European American) she left this experience feeling that mental health services will not provide solace to African Americans given that the mental health system is largely comprised of European American providers. Hazel felt that those in the system are unable to relate and adequately understand how she felt. This respondent believed that she did not receive the feedback that she sought after and thus expressed feeling that professional psychological help was useless in addressing her concerns and thus the system as it is (European American providers) cannot be of assistance. She stated, "I wasn't emotional about it. I just felt like 'again, someone who can't help me.' It's like 'I'm still stuck.' I was coping with a lot and I just didn't have time to waste, you know, about a therapist not working out. I just moved on." Hazel went on to say,

> I was open, I mean this person is a professional. I mean she ought to be able to help me figure out what's going on. Just as a result of a few situations, I just felt that her whole lack of understanding (lack of

understanding of African Americans) immediately began to creep into the relationship and her understanding of how to help me was all wrong.

Jessica spoke of memories of her aunt asserting the following with reference to one's perceived need for professional psychological care, which ultimately impacted her assessment of mental health care, concluding that these services are useless:

> You don't have time for that. What you're talking about is life. If this is all that it takes for you to loose it, you gonna have a hard life. You, me, and everybody else is tired, overworked, and got too many responsibilities. How is some White lady going to tell you how to fix your Black problems?

Her aunt's views were not only that formal mental health services are of no use but specifically that this type of care is incongruent with African American cultural norms as such experiences as feeling "tired, overworked, too many responsibilities" (role strain) are typical of African American life and thus inherently, counseling and/or therapy cannot offer reprieve.

My Way Works Fine

"I Handle It On My Own"

A significant portion of the participants spoke of being able to "handle it myself" when identifying factors that might discourage them from seeking out professional psychological care. Those with a prior history of mental health treatment terminated prematurely due to perceived dissatisfaction with the services rendered and generally feeling slighted by the system (ignorance to

African American worldviews and cultural norms and expectations). These individuals resign themselves to managing their troubles on their own. When asked whether or not she would return to therapy to receive treatment for her major depression, Robin stated,

> No. I could handle it myself. You just have to figure it all out. It's been about two years for me and you have to be able to get yourself out of it. I don't accept it. The depression is real, but for me, I'm beyond it. I won't accept it.

Robin went on to speak about the strategies she utilizes to bring herself out of the depression.

> You can't always think about it. I recognize what it is and I just try not to worry a lot. Which is kind of bad I guess because it's like whatever, it's either going to work itself out or it's not. I can't do anything by being worried. Most times I'll eat something I like, or go buy something, or go somewhere where nobody knows me at all. Sometimes, I just sleep. I know eventually that I'll feel better. I had to build my life from scratch because I have a history of mental illness in my family. So a lot of things affect me in ways that they wouldn't affect other people. I'll get depressed so I have to like, protect myself or figure it out when it comes. Instead of me going back into the cycle, I feel it coming on and I just get myself out of it. And it's been about a year now since I've had it and I can't see myself going back. That's just not happening.

She came away from her therapy experience with firm beliefs about its effectiveness in treating the "non-mentally ill," or persons with depression. Her experience translated into feeling that there is no place for her within the mental health system and that to literally "survive," she must be empowered enough to overcome her clinical depression on her own.

"Look Around You . . ."

Generally, the women spoke of important women in their lives as affecting their unwillingness to make use of professional mental health care as an option for help. Jessica stated,

> My mother always taught me not to be too dependent on anybody for anything. So that when I was a child, for example, if I was sick (laugh), she would always say, "Anything short of death, you're going to school." I had to be practically dead for my mother not to send me to school. So, I think that I took away from that, that I'm supposed to be strong and I should be able to handle it . . . anything short of death. She didn't want me to be cripple when I got older. She never babied me. It was like, "suck it up."

The respondents, generally, learned from significant African American women in their lives that African American women are strong enough to handle their many roles as well as the stress and strain that emanates from their circumstances.

Interviewees came to contrasting the circumstances of other African American women with their own difficulties and assume that they too should be able to deal with their circumstances and get by as those around them have and do. Dina asserted,

> My father got murdered when I was about two years old and the only father that I basically knew was my sister's father and he died in 93 from AIDS, so. I was really raised in a single parent household because even when my sister's father was around, he was only there visiting. A lot, but just visiting . . . he never really lived with us or anything like that . . . My mother does part time work at a school cafeteria and she also has another part-time job at the city newspaper as an inserter. She went through so much to make sure that we were ok . . . I never really knew how things were . . . that things were as bad for her as they really were . . . ever. She held it together and I really respect her for that. She was raising us on no money but she made sure we didn't know that we were struggling, so I just remember being happy all the time. Now, I know that we were struggling and I'm amazed that she dealt with it all by herself. If I can be half the woman she is . . . She's a beautiful person.

Dina perceives her mother as being able to withstand an inordinate amount of adversity and is consequently representative, in her eyes, of what a strong African American woman should look like. She hopes to model herself after her mother and her ability to endure tremendous hardship.

Kimberly asserted, "Realizing what other people's situations are that surpass what I have or ever will go through makes me reconsider how bad I may think my stuff is." In comparing her circumstances to others', she evaluates her situation in such a way that pushes her toward an "it could be worse" position. Another respondent, Michelle stated the following,

When I witness other people's selflessness, I just say to myself that I need to be selfless as well. I think that that helps me to get past my problems. I just think to myself that a lot of people have it worse and I should be thankful that I'm blessed.

The majority of participants find it difficult to discern the severity of their circumstances and are consequently unable to detect instances in which their emotional or personal problems might warrant professional psychological help. Their perceptions of the normality of their issues are based on the type of problems that those around them are likely to experience. Growing up in households where adversity was constant makes their experiences seem much less severe.

"My Circle"

In opposition of mental health services providers, those without prior experience expressed the inability to "logically" envision how counseling or therapy could be of help when there is a presence of a social network (i.e., mother, friend, minister, significant other) able to provide support and ultimately advice in times of distress. From their understanding, support and advice are what counseling or therapy would offer. Irrespective of articulations of how counseling or therapy may deviate from simply speaking to a member of one's social network (e.g., objectivity), respondents seemed to associate professional mental health services with the process of speaking to a member. Joyce declares,

> In the past, I would never address stuff with anyone. I just took it on myself and in time, I realized that that was like the source of my stress. I didn't want to worry anybody with my junk. It finally became unbearable and I started using those avenues (friends and relatives) to release. These are things that I had in my life for a while but I never took advantage of. I just had to kind of step back and think to myself that I need to take advantage because some people don't have what I have (social support). I finally realized that if I allow myself to depend on people when I need to and let them depend on me . . . I don't have to feel this way. I don't have to feel pain because I have that. I talk to them about everything.

This respondent spoke of coming to the realization that it was unnecessary to try and address her anguish on her own. She recognizes that the emotional support rendered by her network during times of enormous stress and emotional turmoil can be helpful in assisting her with managing negative circumstances. To divulge the nature of her circumstances to members of her support system is viewed as possibly safeguarding against any suffering. For this respondent, it is up to her to make sure that she utilizes her support system to its greatest capacity. She recognizes that the members will provide "physical comfort, a listening ear, and advice," such that she does not feel compelled to "get through" times of great stress on her own. The respondent asserted that initially her way of coping was to internalize, yet she realized that she did not have to suffer as her network could provide her with the solace she desired. Generally interviewees were particularly most likely to go to their mothers with their personal and emotional

problems as respondents in the sample reported feeling the closest to this member of their network. A common theme among respondents was the absence of a father figure in their lives. Jessica reported,

> Uhm, my father is very delusional. He didn't raise us. When he was a part of our household, he wasn't there. He would come home really late at night and maybe he would be there for maybe that one night and then we wouldn't see him for a while. My brother only knows him from maybe the hand full of times he's seen him. My sister even less than me. He just was never around. All we had was our mom, but she struggled a lot because it was just one person in the household after my father left. We could have lived a much better life. It wouldn't have been so hard on her. She's my heart . . . I really appreciate all that she did.

As a result, from her vantage point, this paternal absence propelled she and her siblings into closer relationships with their mothers. However, in every case, for one reason or another, respondents articulated problems with relying on their mothers as a source of emotional support. Dina asserted,

> Like I said, it was just the three of us, and so. I think my relationship with my mother is a good one. She's my biggest support. I know that she's the person that I confide in the most . . . no matter what's going on. She's really had my back and I recognize that and you know we have a very good exchange with one another but I think that there are some questions that I have about my childhood and the history that she had with my father and that whole relationship is still kind of vague and unclear that I really

don't feel comfortable opening those things up. I do think we're very close though. But I know that because I don't feel like I can really talk to her about anything and I kind of feel like she's sacrificing my feelings (by not disclosing information about her father) so that she's ok. I can't really tell you how this has made me feel. I sometimes feel like "damn . . . you don't really know who you are." So, there is some space there I guess when I really think about it. So a lot of that, the reasons why that is, I have questions to but I feel like if it wasn't really voluntary than maybe I shouldn't question it. I'm really concerned about that, because she hasn't talked about it on her own, maybe it's a real sensitive issue to her.

Dina spoke of her perceptions of her mother's own pain that seem to render her unavailable to her daughter in certain ways. Consequently, from the respondent's point of view, in speaking to her mother, she risks the possibility of causing emotional distress and paradoxically ending up caring for her mother's needs when she turned to her mother initially to care for her own. Thus, Dina has yielded in response to her perception of her mother's fragility. She expressed feeling stuck and feels unable to move beyond these feelings yet momentarily goes on to entertain the possibility of making use of a mental health professional in addressing her family concerns, yet finds herself justifying why such efforts would ultimately prove ineffective.

I'm not sure if she's even aware of those issues and I think that maybe having a 3rd party or a mediator (counselor or therapist) would kind of encourage opening up those things where I don't really feel like I can

because I get the sense that all of that is still so sensitive . . . it's been so long and I'm not really sure why it would still be an issue or why is should keep me from knowing who I am. I think she thinks that because I didn't know him that maybe it doesn't really affect me. Or maybe she tried so hard to make sure that my life was good so that him not being there wasn't as bad . . . Maybe having the 3rd party would help that. But if I tried to make her go see someone, she would be like, 'no . . . for what . . . this isn't really anyone else's business.' I know she would never go so. (Under her breadth) I'll talk to her eventually about all this. I think she would feel like that person doesn't understand because they haven't been through it. Having someone else trying to get involved would be weird. That would be weird. My mother would probably end up pissed off and (laughing) she wouldn't tell me anything.

As in the case of other respondents, Dina finds that the emotional support of family members brings with it opportunities for her emotional and personal needs to go unmet; that there are both costs and benefits to attaining this form of help. Another participant, Michelle, asserted,

> My relationship with my mom is much better now. I open up to her a lot more. I don't really want any advice from her though . . . Forever, I was the mother and she was the child. My mother was an alcoholic and was in and out of abusive relationships. I remember many times where I had to literally pick my mom up off the ground down the street from our house . . . I was like 8 or 9 years old. People use to knock on the door and say, "your

> mom is down the street again." I remember I use to watch my stepfather beat her up and down the stairs. She would have blood everywhere. I was the one that wiped her face and put Band-Aids on her cuts. She didn't do that for me. She use to not take care of me. I was the only one still in the house because I was the youngest. My sisters and brother bounced. I use to go to school hungry and dirty. But she got help after my sister couldn't take care of her kids and so my mom took them in. She doesn't drink anymore and we finally found out that my mom is Bipolar. She takes medication and she sees a therapist.

In certain instances, these individuals are unable to provide the type of support needed. For example, Robin spoke of confiding in her mother about her then, not yet diagnosed depression, only to feel misunderstood and thus unsupported. She stated,

> She's more practical and physical and I'm more like, ahh . . . out there somewhere. Like I'm physically here because I have to be but if it were up to me, I would probably be gone somewhere in another form. So certain things I do talk to her about, but even though we're alike, she don't even be understanding what I'm talking about. She be like "ok." Most of the time, I don't really trust her to tell her what's going on because every time I would say something, she would think it was so wrong or bad or something or even crazy and then it would piss me off because it was like she didn't understand and I got even more frustrated. So I just stopped trying. I'm just like you don't even understand so I'm not even going to go

there. So there are definitely things that I wouldn't talk to her about but they're things that I really don't tell anybody.

Robin found that despite her efforts to gain the type of support she desired from her mother (i.e., "Just for her to listen to me and be like a sounding board and to remind me of my train of thought"), she left the conversation feeling misunderstood, frustrated, and hopeless. As a result of turning to their support network for help in addressing their symptoms of a clinical diagnosis and coming away without at least consolation and validation, this respondent, and others, found themselves "turning inward" or "looking to self" for relief.

Other women found themselves feeling looked down upon in some instances by members of their social network. Hazel, with unsatisfactory interactions with the mental health system, she finds that the responses that she is likely to receive from members are unhelpful and in some instances, leave her feeling humiliated.

> When my sisters or my mother give me advice, they're kind of like "look . . . you've been going through this with that man forever . . . if he's not making you happy just leave." I don't feel like they really understand what I'm going through and my fears. They seem like they're really just tired of hearing about it. Don't get me wrong . . . it is helpful for them to 'break it down for me' but I don't need them to make me feel stupid. Like they're trying to make me feel like I'm ridiculous and pitiful for going through all of this. I guess they think that that's going to make me get out of the situation but that's not what I need. They try to tell me about what I need to do and

none of them have marriages like mine. I'm like "look, you don't know what you're talking about," I mean not that, they do but come on. They've never been faced with anything that I've been faced with. I know that they are just trying to help but that's not what I want or need from them. I've been depressed about this forever and their like, "what's wrong with you?" They don't understand . . . they think I'm pitiful because I haven't gotten out of it.

She went on to say,

For example, my grandmother is like "well it takes at least three marriages to get it right." So she's not really like struggling with the type of issues that I'm struggling with. But, and, my mother is like well "if he's not doing what you want than book" or "if he's not doing what you want then the hell with him" but that's not really how I'm going to role and that's not . . . Actually none of my sisters are rolling that way, especially not my sister in-law. She has had the most influence in terms of being a Christian wife and uhm that is not what the Bible says to do, so this is like 180 degrees difference from what we saw or better yet, heard. They think you can just cut out and start all over again and even my grandmother stayed with my grandfather and took care of him until his death and he was an alcoholic. So you know she didn't do that. So you see, she didn't take her own advice.

The majority of respondents talked about the emotional support they receive from significant others. Janet stated,

> Uhm, yeah he knows everything about me. He's the person that I can tell everything to. The stuff that nobody knows . . . he knows it all. He tries to get me to figure out the root of my problems and how I feel and bringing it to my attention so that I have a variety of ways to look at the situation or to address it. I think it's more of a listening than giving me suggestions. More encouraging me to figure it out on my own. I think that's what I need from him. He does what I need from him.

As with other members of one's support network, however, these women find that significant others often cause added complexity or may in fact be the source of psychological distress. They spoke of feeling disappointed and frustrated with the weight they are made to care in response to their significant others. For instance, Jessica asserted,

> He's going through a lot right now . . . changing as a person as he was when I first met him. He goes through these depression periods where he, well not depression, but like he feels like he can't get his stuff together. He hadn't worked for a while and he was going from job to job. He has a problem keeping a job. When he's with me, I'm that stability and so he wants to keep me around. I have been more of a mother to his kids than their mother . . . Now he has his sons. A lot of the things we're going though right now, well, he's not accomplishing what he thought he would accomplish by moving away. I said that he should stay here and we'll work on this together. "I have your back and even if things go bad I'm not the kind of person that would leave you." But I knew that I couldn't support him

and 4 four kids so his decision to move back with his mother, I was like "ok, I can respect that." He's trying to be true to himself and by him trying to do that, he's disrespecting other people, especially on the job. I just can't deal with it. Because of his stuff, he's not giving back to me. He's very spoiled, very needy. He's so smart he can do anything but he doesn't feel that he has that potential.

Jessica spoke of her significant other's current circumstances as requiring immense support. He finds himself feeling disappointed with his inability to fulfill his aspirations. Her significant other has ambitions and makes resultant decisions that have lead to significant financial strain as a struggling single father of four children. Because of his yearning to make his dreams come to fruition, he makes impulsive decisions that render him in consistent need of both financial and emotional support from others. In consequence, she takes on additional roles and assists him in ways that are beyond her means in an attempt to express her unconditional support. Jessica was, however, able to recognize her limitations. As a result of his distress and subsequent behavior, she experiences him as unavailable, self-centered, and unable to offer the type of support she expects of a partner. Yet at the same time, Jessica feels bitter, though willing to sacrifice her needs in response to "feeling sorry" for his negative perceptions of himself and constant obstacles. She does, however recognize him as honorable and views him as "good man" as he is raising his four children on his own.

No More Than I Can Bear

Typically, the women spoke about emotional and psychological concerns as being, Robin articulated, " . . . more spiritual than they make it out to be." She observed emotional distress as being a consequence of a lack of faith and a spiritual relationship with God. The belief was that the problem is outside the realm of therapy and thus therapy has nothing to contribute to alleviating the problem. One woman quoted her mother as saying,

> Oh girl please . . . you can't pay nobody to make you feel better. What you need to do is be in the church. You live walking distance from a church and still don't go. If you would learn how to have faith in God, he's the only one that can bring you peace. You can't get that from nobody. He cures all. You just need to pray.

Kimberly expressed,

> My mother always told us that God doesn't give you anymore than you can bear. So you ask yourself, "how can I be going through this and that," and . . . and God teaches you that if he didn't think that you could handle it, then he wouldn't give it to you. So to overcome that is really something to be proud of and just reassurance that God has faith in you and knows that you can handle it. He's just testing you and when it ends, you know that you passed.

"God does not put on you anymore than you can bear" captures a number of participants' perspective on addressing their concerns with mental health professionals. Their attitudes and perceptions of their ability to weather their

circumstances deter them from ever conceiving of the mental health system as an appropriate alternative.

When asked to articulate their feelings about their relationship with God and what this relationship provides them with, Robin replied,

> He gives me comfort that the person I am now is not the person that I'm going to be so that I know that if I do jacked up stuff, it's like "dang that's kinda jacked up." But he knows that I'm actively seeking growth and change. He understands where I'm at and he's letting me grow and we change together. So, its not if I do this and that, I'm going strait to hell. My God, (under her breadth and smiling) I don't know who yours is, is like, "ok, I'm working with you and you're working with me." It's just like I may do this and that and I don't know why and I like it (e.g., promiscuity) and I don't want to stop but I will when I grow and change. That's my comfort. Knowing that I'm growing and that I'm changing.

This woman articulates the need to be understood and finding herself feeling understood in her relationship with her God. The God that she has come to be most familiar with as a child (retaliatory and frightening) and young adult is not the God that she has come to know and have faith in today. Robin describes the God that she believes in as much more forgiving, understanding, and is followed out of reverence as opposed to fear. She perceives organized religion (i.e., church goers) as valuable for some, yet not for her own purposes. "It's a place for it. Some people need that kind of focus and structure. But my relationship with God is more like he understands where I'm at and he's letting me grow and we

change together." Robin described her God as less punitive and much more tolerant of her fallibility than traditional religious doctrines. She reports feeling that though she may engage in behavior that is unacceptable by most standards (e.g., promiscuity) and may be unaware of why she engages in such behavior and why she finds it difficult to stop, God understands the issues motivating her actions. Feeling completely understood provides relief and anticipation of something better. God is able to forgive her behavior, as God knows the purpose of such behavior in her "life story." Robin views the "bad" as a necessary piece of her narrative. She expressed finding comfort in knowing that although she may be experiencing trials and tribulations at present, her suffering will come to an end. Robin may feel disappointed or unhappy with the person that she has become, yet her faith provides her hope in knowing that she will change and grow . . . that things will not always be as they are now.

Hazel reported,

> I first go to my family . . . my mom, my sisters . . . I go then to my pastor, well not to my pastor, a minister in my church. I was very depressed and I am feeling so much better, like I'm slowly, like taking control of my life again and with both marriages, I found marriage to be depressing, uhm, depressing, disappointing, uhm, hard, uhm, hard work, and uhm, I guess that's enough (laugh). I guess that's enough (laugh). Uhm you know and so that's why God provides such a good source of strength and comfort for me and that's why I really feel I can go on in my marriage because no one is perfect, I'm not perfect, my husband isn't perfect, but uhm, we are

taught in the bible to honor ourselves as a gift and we're supposed to honor that gift and that we can do that for God as opposed to for your husband because if it's for another person, that person isn't perfect, you know?

This woman, as well as others, proclaims feeling that God gives them the understanding, tolerance, and patience necessary to navigate life, relate to others, and ultimately be happy in relationships. God has provided her with the ability to continue in spite of disappointment. She has come to realize that her searching for perfection in others in order to be happy is impossible and that in the end her happiness will come from "letting go" and realizing that her contentment will be derived from her within and patience and acceptance.

Many women spoke of God providing a space to reflect on their blessings despite their anguish. Again, their faith in God brings protection and the assurance that things "could be worse" and to be thankful that they are not. Their faith provides them with the understanding that they will never be forsaken and will always be able to seek salvation in God.

It gives me strength and guidance to realize that I have been placed in a situation where I have been blessed and that only God can provide me with those blessings. I'm not alone and that I have shelter and that learning more about myself I want that spiritual guidance so that I can feel a certain way, that stress reliever, because the world is a stressful world. I can know that I have that protection. God is the one thing that I could count on.

Kimberly concurred by declaring that God provides her with, "Security, definitely because through it all, No matter what it was, I could always pray and feel better. So, that's what it offers me. Security and I don't have that anywhere else."

Community Perceptions

Many respondents spoke about their community's views of professional psychological care as a practical option for providing assistance in times of emotional turmoil. Most reported that in their opinion, the African American community is against the use of professional psychological care unless you are "mentally ill." Hazel asserted,

> Uhm, I know a lot of Black people don't immediately think of seeing a shrink or something for help. That's kind of unreasonable for most (Black) people. I mean not everyone can afford a $150 session once a week and if you're covered, most people are going to want to go in network and I think it was bell hooks who said something like you can't expect to get good therapy by going through your insurance. It's not assessable to people. Plus, I think the things that happen to Black people are just looked at as sort of everyday things that happen to people of color and so most people think that if you go, you must crazy. I mean, you need a shrink. It must be really bad. I mean there's so much working against it. It's looked at very negatively and a lot of Black people see it as a White thing or like it's some kind of extravagance or something. I mean I know people, my friends who don't have a problem with going to see somebody

professional, but these are people who have a lot of education and can afford to do that. They're probably the people who need it the least, ironically, but . . . I don't know.

It was the general consensus among many participants that counseling or therapy is not only shunned in the community but that these services are economically inaccessible even for those who might contemplate its use. These circumstances further validate perceptions of mental health services as an impractical option thus further contributing to stigmatized views of mental health care and mental illness as well. Specifically, either you're able to "afford" such services or you are "mental ill." Those with more education and can "afford" the cost of mental health care are perceived as generally more open to professional psychological help as an option. Those who assess themselves to be in need of formal care and can afford those services through insurance or other means are observed as indulgent and more aligned with European American cultural norms. Kimberly supported this notion as she asserted,

> . . . not everyone can afford to not feel like getting out of bed . . . as if depression is something for privileged people. Feeling depressed is kind of normal given where Black people are. People aren't able to just run to a therapist every time they feel like it's too much to take. Everyone goes through depression and for Black people; you just don't go and pay someone to solve your problems . . . everybody gets depressed and I personally don't know any Black people who can afford to do that. I don't think that the Black community believes in that "talking cure" thing. They

want help that's going to be more proactive. It's like it doesn't really make much sense. It's like, "I'm depressed because I'm tired of taking care of these five kids or whatever and my husband can't get a job . . . hell, find my husband a job and I'll feel better." I think that may be how the community looks at it, but I can't really speak for all Black people.

Dina stated,

Just being afraid of opening up and talking about your stuff to a stranger or you think you may not be appreciated for doing that . . . if I was seeing someone, I don't know if I would let people know. "You're not crazy . . . what are you doing?" It's shameful. It's a reflection on your family. You're going and talking about your people . . . I think we're (the African American community) expected to use other resources. (Grimacing) I mean we (the African American community) don't really look at therapy for that kind of thing.

This respondent as well as others spoke about the cultural incongruence of mental health services in the African American community.

Jessica talked about an instance in which she recalls speaking to her mother about feeling extremely depressed and even suicidal. At this point, the respondent "admitted" the contemplating seeking help from a professional as she appraised her symptoms as being severe enough to warrant the assistance of a mental health care provider. She recollects her mother's response as being, "What (waiving her hand toward the respondent in a downward motion)? All that I do for you . . . I do everything that I can. I don't understand. The problem is that I

do too much for you." Her mothers' reply evoked feelings of shame. She felt that she should be thankful and that she has "no right" to feel as she did . . . how self-consumed. She experienced her condition as a betrayal. To receive help, "as if it's that serious" and the inability to "not make it go away" on one's own was a direct insult on her mother's parenting and ability to fulfill her needs. Jessica likened speaking to a mental health professional with "badmouthing" her mother's parenting capacity. As such, she reconciled her situation by "dealing with it" herself. Jessica "refused" to succumb to her sadness.

> I just tried to make myself happy and recognize that I'm blessed and that I don't have anything to be unhappy about. That's just how Black people see it. It's like, you should really be thankful. You have education, a roof over your head . . . a pot to piss in . . . and I (respondent's mother), I tried to make sure you have it better than me (respondent's mother).

Respondents appeared to equate divulging information to a mental health professional with "telling" on the inadequacies of one's family . . . speaking of family business. Janet, "I would never go to counseling because my mother has made me a well-rounded person. I don't need it. I don't ever go to therapy because I don't need it . . . I don't care what's going on, I know that nothing would ever be that bad."

CHAPTER V

Discussion

> The significant problems we face cannot be solved at the same level of thinking we were at when we created them.
>
> Albert Einstein (1879 - 1955)

The purpose of this investigation was to explore and broadly describe issues significant to patterns of mental health care utilization among African American women. There were three research questions guiding this investigation: 1) What are the range of definitions, thoughts, feelings, and views held by African American women relative to professional mental health treatment? 2) What are the perceived barriers and incentives to seeking out formal mental health care? 3) What are the kinds of problems that African American women consider appropriate for this form of help? A qualitative research design allowed for the examination of the full experiences and perceptions of participants from their own point of view and in their own words. To accomplish this task, a semi-structured interview format was used.

Purposeful sampling (Merriam, 1998) was done to recruit self-identified African American female participants at least 18 years of age. Semi-structured interviews were conducted over a 6-month period in respondents' homes until saturation was reached or until the data became redundant with that which had previously been collected (Glaser & Straus, 1967; Merriam, 1998). Interviews were conducted with a total of 8 African American women and data analysis (constant comparison) took place concurrently with the data collection process.

As a result of an inductive analysis of the data emanating from the interviews, four themes emerged: *It Doesn't Work, My Way Works Fine, No More Than I Can Bear,* and *Community Perceptions*. These themes captured the range of definitions, thoughts, and feelings held by African American women relative to mental health care in general and in relation to themselves as their responses clarified what motivates and/or deters the from seeking out professional mental health care. What follows is the integration and summary of the emergent themes, creating an image of the processes affecting patterns of mental health care utilization. The next section will present the context of the four themes.

Attitudes Toward Mental Health Care Utilization in Context

It Doesn't Work

When asked to provide a description of their understanding of and to form opinions about professional mental health care, overall, participants tended to characterize counseling and/or therapy as the process of speaking to a professional capable of offering "objective advice." Participants viewed mental health care providers as professionals who received training to assist clients/patients in uncovering information pertinent one's circumstances that may not have readily been apparent to the client/patient before. Participants held the view that to get to the root of the issue would propel the client/patient into an understanding essential to making changes that will finally bring an end to one's suffering. While participants commonly gave favorable responses regardless of

whether or not they themselves had ever had previous experience with mental health services, paradoxically, the majority believed or experienced mental health professionals to be of little assistance in addressing their concerns. Though it would seem that favorable perceptions would be most significant in motivating one to consider formal mental health care or for those who received care to have resisted premature termination, it was the interaction of multiple factors including favorable perceptions that informed whether counseling and/or therapy might be considered as a means of addressing psychological distress or whether past clients/patients continued with their counseling and/or therapy.

Those without a history of mental health treatment had numerous concerns. For one, participants expressed their fear of potentially coming away from the experience without relief. These women viewed professional psychological care as a last resort in instances (i.e., crisis) in which no other alternative is available, all other resources have been depleted, or in which case no other avenues are appraised as being of potential help (i.e., social network). These results mirror the results of past research that found that indeed African Americans tend to prefer "emergency services over ongoing treatment services, tertiary prevention over secondary prevention, and crisis mode over preventative mode" (Morris, 2001, p. 564). The very thought of conceding to this "taboo" phenomenon and "humiliating" oneself by entering this system of care to ultimately be disappointed is enough to prevent one from looking to the mental health establishment for help. Much like those without a history of mental health treatment, participants with previous care spoke of entering therapy in hopes of

receiving immediate relief in ways that would instantaneously and reasonably assuage their anguish. Interestingly, consistent with past investigations, though many African American women either delay or fail to seek treatment, there appears to be a relationship between help-seeking and depression (Barbee, 1992). Specifically, respondents who sought formal care were ultimately diagnosed with major depression. These findings support the results of previous studies, which suggest that when African American women perceive their problems to be severe, they are likely to seek treatment (Mays et al., 1996; Morris, 2001). This is not to say, however, that other respondents without care did not or have not experienced symptoms of depression or other serious disorders, yet those who admitted to utilizing mental health care in the past were participants diagnosed with major depression. Nonetheless, though these individuals made contact with the mental health care system, while in therapy, the process was perceived as inconsistent with what should logically take place or help came in ways that validated preexisting and stereotyped fears of what counseling or therapy would offer (Sussman et al., 1987). These participants derived negative perceptions from their experiences of the propensity for counseling and/or therapy to effectively address their concerns and terminated treatment prematurely, declaring that the professional service delivery system is an unfit option for help. Again, this finding is consistent with past investigations, which found that those who do utilize counseling and/or therapy are likely to terminate treatment prematurely (Sue, 1977; Acosta, 1980; Flaskerud & Hu, 1992).

Ironically, all participants diagnosed with major depression were subsequently referred for a psychiatric evaluation to be assessed for medication. Past studies suggest that African Americans are actually more likely to receive treatment with medications than do European Americans with comparable symptoms (Flaskerud & Hu, 1992). There may have been a justifiable rationale in each case; however, these circumstances do complicate the issue. Conversely, consistent with prior research studies, these women may in fact have presented for treatment once their problems were perceived as severe (Mays et al., 1996; Morris, 2001) and depending on a multiplicity of circumstances may have necessitated the use of medication. Nonetheless, these women experienced their treatment as wholly inconsistent with what should reasonably take place given their presenting symptoms and existing assumptions about treatment. All believed medication to be recommended solely in instances of "mental illness." For these women, "mental illness" represents severe psychopathology or disorders in which psychosis is likely to occur. Persons who are "mentally ill" are those who experience a loss of reality, are unable to see and respond appropriately to the everyday world, and lose all reason and control. These women differentiated their circumstances from those described above; concluding that "mental illness" is not an appropriate characterization of their symptoms (major depression) and thus would not qualify for a recommendation of medication. Their cultural conceptions of mental illness (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999) proved significant to their refusing to comply with the recommendations they were given. From their experiences,

initially going into treatment and ultimately receiving recommendations that were perceived as inappropriate for their symptoms, validated previous assumptions that treatment is exclusively for persons with severe mental illness.

Further hindering these women from seeking out mental health services was the notion that counseling and/or therapy is wholly inconsistent with African American cultural norms (Mays et al, 1996). These services are thus not perceived as desirable or helpful (Wallen, 1992), particularly among those who are strongly racially and culturally identified. In addition, these women have come to understand that feeling overworked, tired, overwhelmed, strained, etc. are conditions to be expected by all African Americans and African American women in particular to some extent (Carrington, 1980). Thus inherently, counseling and/or therapy cannot offer reprieve (Wallen, 1992). Mirroring the findings of prior work (Neighbors & Jackson, 1984; Mays et al., 1996), nevertheless, the mental health system was believed to be ill prepared to address the concerns of African Americans anyhow as interviewees viewed the mental health system as largely comprised of European American providers, which were believed to be incapable of addressing "Black problems." Participants expect that services provided by European American would be less germane, less influential, and less satisfying (Wallen, 1992). These assumptions may in fact hold some credence as evidence suggests that services provided have largely proven biased, incomplete, and deficient, as similarities to European Americans have continued to be emphasized while differences have essentially gone ignored (Dana, 2002). For instance, African American clients/patients are significantly more likely than

European Americans to be hospitalized or diagnosed with schizophrenia or other psychotic disorders, whereas European Americans are more likely to be diagnosed with personality disorders (Strakowski, 1995). Further, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) underscores the universality of psychiatric disorders despite cultural influences on symptom patterns and symptom presentation (Brown et al., 2003). Additionally, minority group clients/patients are more likely to receive severe and stigmatizing diagnoses, to be inappropriately diagnosed, and to have less positive mental health outcomes (Mathews & Hughes, 2001; Morris, 2001). Needless to say, training programs continue to educate future providers to rely on Euro-centric paradigms, reflecting the attitudes and values of those who developed it (European males). According to Morris (2001), "Because traditional clinical therapy and practice are grounded in Western assumptions, there is a high probability that many clinicians and diagnosticians are 'operating in the dark' when working with African American clients" (p. 566). This framework provides for standards of normality that are analogous to those characteristics found and valued among the dominant culture and those who dominate within (Taylor, 1999). "Because of limited cultural information, there is the potential for service providers to make faulty assumptions, inaccurate diagnoses, incongruous treatment plans, and inappropriate assessment protocols" (Morris, 2001, p. 566).

Respondents concluded that without mental heath professionals who share a similar cultural background, past and potential clients/patients ran/run the risk of being subjected to care that is clinically inappropriate or inadequate in

explaining and treating their symptoms (Watkins, Terrell, Miller, & Terrell, 1989). This threat has given rise to extensive research focused on the effectiveness of client-therapist matching on race, culture, and ethnicity in psychotherapy. According to Sue (1998), the most important benefit of matching is an increase in the total number of psychotherapy sessions attended. Ethnic matching has consistently been related to increased treatment duration and decreased termination rates (Flaskerud, 1991; Sue et al., 1991). Further, previous investigations have steadily revealed direct relationships between the number of sessions attended and treatment outcomes (Orlinsky, Grawe, & Parks, 1994). From the outtake of therapy, client-therapist racial, cultural, and ethnic dissimilarity create "invisible boundaries . . . established between service providers and African Americans" (Morris, 2001, p. 564). For instance, Thompson, Worthington, and Atkinson (1994) found that African American clients report lower levels of rapport with European American counselors, accordingly affecting perceptions of the counselor's effectiveness. Other studies have found that African Americans have lower and more negative expectations of their encounters with European American counselors or therapists (Watkins et al., 1989). These individuals consequently perceive European American counselors as less credible sources of help. European American counselors and therapists are less likely to discuss issues of race, discrimination, oppression, and other sociopolitical factors which may be of great importance to the presenting concerns of African Americans (Atkinson, Thompson, & Grant, 1993). Given that European American clinicians continue to make up the majority of mental health

professionals, this mistrust in the competence of service providers continues even prior to the first contact is made thus widening the gap between African American women and treatment (Nickerson, Helms, & Terrell, 1994).

My Way Works Fine

Another element influencing the lack of motivation to utilize mental health services contributing to poor access to professional psychological help is the sense of "self-efficacy" that participants felt in their ability to handle their distress on their own. In opposition of making use of mental health services as a means of alleviating their personal and emotional pain and suffering, regardless of the severity of their problems, participants chose to "figure it out" (Mays et al., 1996). This reluctance to seek help is contradictory when considering the range and severity of problems they face (i.e., acute and chronic life stressors, lower socioeconomic status, unfair treatment or discrimination, role strain, poor access to material resources, etc.).

The majority of participants spoke of the influence of important African American women in their lives on their unwillingness to make use of professional mental health care as an option for help in alleviating their distress. Specifically, many expressed learning that African American women are strong enough to handle their many roles as well as the stress and strain that emanates from their circumstances. Several spoke of contrasting the conditions of other African American women with their own difficulties as a measure of the severity of their problems and accordingly, affecting decisions of what, if anything should be done. This phenomenon is described as normativeness, or the extent in which

others are observed to be sharing an experience or displaying a specific behavior/s (Cialdini & Trost, 1999). Several interviewees reported examining what other African American women do in response to particular situations, providing strategies for what should or should not be done (Addis & Mahalik, 2003). As their perceptions of the normality of their issues are based on the type of problems that other African American women are likely to experience, these women are also inclined to minimize the severity of their circumstances when others are dealing with situations that seem much more extreme than their own. Growing up in households, for instance, in which adversity was constant makes their experiences seem much less acute. Their issues are perceived as being problems that are surmountable without the assistance of professionals. Consequently, their perceptions of the normality of their experiences thus have a significant influence on their ability to seek out appropriate help.

Many spoke of observing African American women as being able to withstand an inordinate amount of adversity. For these women, the ability to "successfully" withstand great suffering is to be commended (Mays et al., 1996). As such, they aspire to model themselves after those who are representative of what a "Strong African American Woman" (Romero, 2000) should look like.

> "Strong Black Woman" is a mantra so much a part of U.S. culture that it is seldom realized how great a toll it has taken on the emotional well-being of the African American woman. As much as it may give her the illusion of control, it keeps her from identifying what she needs and reaching out for help (p. 225).

One's ability to be self-reliant, self-contained, and possess the determination and capacity to deal with the adversity associated with being African American is a central component to the identity of these women (Romero, 2000). To be a Black woman is to be a "Strong Black Woman." This element of the identity of African American woman renders them unable to discern the severity of their circumstances and are consequently unable to make good decisions about instances in which their emotional or personal problems warrant professional psychological help (West et al., 1991). This cultural conditioning results in prescribed patterns of behavior and responses (Link et al., 1999). The socially constructed image of the "Strong Black Woman" may also work to decrease the totality of emotional support available from other resources as they are unable to realize the full spectrum of their problems, thus discouraging self-perceived need for formal or informal mental health care (West et al., 1991; Romero, 2000). These women shy away from the notion of seeing a professional in particular, as they themselves, their families, and their community would view this as a sign of weakness and failure as a Black woman.

Other factors that contribute to the discrepancy in mental health care utilization was the inability to "logically" envision how counseling and/or therapy could be of benefit when one's social network is perceived as able to provide the support necessary in instances of personal and emotional distress. In Barbee's (1992) qualitative study of women's attitudes toward their depression, she found that interviewees perceived their social support (friends) as one of their most important resources in helping them to deal with their symptoms of depression.

According to Myers (1980), social support for African American women is described as ". . . those helping agents . . . who provide social support and feedback in solving problems or during periods of crisis" (p. 26). The emotional support provided by social networks has proven to be an invaluable coping mechanism for maintaining mental health and well-being, especially during times of immense stress among African American women (Gray & Keith, 2003). Yet, not in every case will the support offered by social networks be sufficient to address one's concerns. Irrespective of articulations of how counseling and/or therapy may deviate from speaking to a member of one's social network (i.e., objective, professional advice), respondents were ultimately misinformed as they likened the services provided by mental health professionals to the process of speaking to a friend, minister, significant other, family member, etc.

The results of this study indicate that respondents are most likely to turn to their mothers for assistance in addressing their personal and emotional problems. Many believed that growing up without a father in the home or with a series of inconsistent father figures (Boyd-Franklin, 1987) propelled them into closer relationships with their mothers early on. Yet, by and large, for one reason or another, they reported their mothers to have failed to give expected and adequate emotional support. In fact, while some mothers are able to function as great emotional supporters most of the time, most respondents found their complex relationships with their mothers to various degrees, the impetus of many of their concerns or at least contributed to the stress currently felt (Gray & Keith, 2003). Moreover, with respect to the support they expected to receive from

significant others, these women expressed the pessimism so prevalent in the African American community (Boyd-Franklin, 1987). They have few positive expectations and find themselves sacrificing their own needs to care for the needs of their significant others. All in all, the personal characteristics, qualities, and the state of supporters' own psychological health may more accurately determine their ability to provide adequate support (Gray & Keith, 2003). In addition, the severity of one's presenting concerns establishes the network's ability to provide proper support. As such, there are benefits to seeking the assistance of members of one's social network, yet there are costs as well (Carrington, 1980; Neighbors, 1997).

No More Than I Can Bear

"Since slavery, the Black church has served a critical role in Black women's lives. God is seen as a deliverer from unjust suffering and the comforter in times of trouble" (Musgrave, Allen, & Allen, 2002, p. 557). Specifically, participants spoke about their emotional and psychological concerns as " . . . more spiritual than they make it out to be." Respondents tended to view their emotional distress as a consequence of a lack of faith and a spiritual relationship with God. To reconnect or "work" on that relationship is the sole way to provide an end to ones' suffering as there is a strong link between spiritual and psychological well-being (Brown et al., 2003; Lincoln & Chatters, 2003). Thus, at the heart of this belief is that one's emotional and psychological distress is outside the realm of therapy and thus cannot contribute to alleviating the problem. This perspective enables this population to optimistically maintain its

ability to reason when confronted with victimization, to alleviate and prevent despair, and to provide meaning to the suffering experienced from oppression and marginalization (Lincoln & Chatters, 2003). Overall, religion provides many with a framework from which to understand and explain and functions as a vehicle for coping with difficult situations.

"God does not put on you anymore than you can bear" captures a number of participants' perspective on addressing their concerns with mental health professionals. Their attitudes toward their ability to weather their circumstances deter them from conceiving of the mental health system as an appropriate alternative. Religious coping resources thus influence how African American women perceive their mental health, determine the etiology of psychological distress, and go about making decisions of what should be done (Corbett, 1998). It has also been suggested that African American women may deny they have a problem if religious coping mechanisms are unable to provide them with needed help (Corbett, 1998). These factors may contribute to why African American women generally tend to resist treatment until their problems become extremely severe. Even still, in instances in which interviewees spoke of circumstances in which one might seek out mental health care or situations in which mental health services were sought after (i.e., suicidal ideation, major depression), many found members of their social networks discouraged the use of this resource as supported in the literature (Addis & Mahalik, 2003). Instead, they were often directed to turn to the church or to pray.

Community Perceptions

Many respondents spoke about their community's views and the negative stigma attached to professional psychological care. These women thus experience barriers to access to help as they perceive their community as disapproving of the process unless "mentally ill." Thus, mental health care utilization by African American women may appears to reflect sociocultural barriers based on shared ethnic identity as suggested by Mays et al. (1996).

A number of participants believed that counseling and/or therapy is not only rejected as a source of help by the community, unless in crisis, yet that these services are largely economically unfeasible even for those who might contemplate its use. According to Morris (2001), with the further marginalization of African Americans by managed care and other insurance companies, access to quality mental health services has become more difficult and costly. Potential clients/patients who might have made use mental health services are now confronted with another barrier to access (Morris, 2001). However, according to prior investigations, low utilization rates do not necessarily indicate the absence of health insurance (Caldwell, 2003) as those with insurance that covers the cost of mental health care refrain from making use of mental health treatment. Nonetheless, regardless of whether or not participants had insurance that would pay for such care, these women still held on to perceptions that mental health care is largely unaffordable and is to be used in instances of crises. Specifically, either you're able to "afford" such services or you must be "mental ill" (conceptualized as severe psychopathology; depression does not fit within this

framework) if professional psychological care is necessary. Those possessing more education and can consequently "afford" the cost of mental health care are perceived as generally more open to professional psychological help as an option (Caldwell, 1996). More education bestows more exposure (to European American culture) and therefore more alternatives. Those who assess themselves as being in need of formal care and can afford those services through insurance or other means are observed as indulgent and more aligned with European American cultural norms as counseling and/or therapy is fundamentally viewed as a European American phenomenon. European Americans are observed as more apt to utilize such services under non-emergency circumstances. The general consensus is that no traditionally acculturated [extent to which ethnic-cultural minorities participate in their own cultural traditions, values, beliefs, assumptions, and practices versus the dominant European American society (Landrine & Klonoff, 1995) African American would desire professional care.

Several women spoke of the cultural incongruence of mental health services in the African American community, particularly focusing on the forbidden practice of "putting your business out there." It is the perception of many that to speak to a "stranger" regarding ones' family secrets is highly inappropriate. The predominant perception is that the theoretical framework used to conceptualize the circumstances clients/patients within the mental health establishment places emphasis on insufficient parenting and childrearing as the etiology of one's psychological distress. On the other hand, participants believed

that African Americans should never be disloyal to his/her family by speaking unfavorably about those who are responsible for one's existence. At the same time, the African American community too, views mental illness as a consequence of the way in which a person is raised. As such, interviewees tended to liken divulging information to a mental health professional with "telling" on the inadequacies of one's family. One participant spoke about an instance in which she recalls speaking to her mother about feeling extremely depressed and suicidal. At this point, the respondent disclosed her intention of making use of professional psychological services as she appraised her symptoms as being severe enough to warrant the assistance of a mental health care provider. She recollects her mother's response as evoking feelings of shame and betrayal. To proclaim one's circumstances as being severe enough to warrant professional attention is to suggest that one's childrearing was inadequate as it led to poor mental health.

These results mimic the work of Link and colleagues (1999) in 1996, as mental illness was perceived by the larger population to be a consequence of childrearing. However, currently, childrearing practices are perceived as less important in these disorders than stressful circumstances and biological and genetic factors (Link et al., 1999). The general population has moved toward a more multi-causal perception in which in addition to stressful circumstances, chemical imbalances in the brain, and genetic factors are also viewed as important contributing factors (Link et al., 1999). This understanding is consistent with the predominant views of mental health care professionals today. Yet, it

appears, as evidenced by the current study, that some sectors of the population continue to foster the perception that poor childrearing is to blame for the development of mental illness.

Conclusions

Several explanations for the underutilization of mental health services by Africa Americans, and African American women in particular have been presented. For instance, prior investigations suggest variables such as differences or unrealistic treatment expectations between clients/patients and providers, a lack of perceived need (West et al., 1991; Mathews & Hughes, 2001), potential clients/patients being discouraged by loved ones (Caldwell, 2003), clinically inappropriate or culturally inconsistent services, and the negative stigma associated with going "outside" of one's community for help (Morris, 2001) are all variables found and/or theorized to lead to discrepancies between the use of mental health services and need. In addition, previous studies indicate that African American women tend to emphasize somatic aspects of psychological distress thus turning to primary care settings (Brown et al., 2003), fear treatment and hospitalization (Sussman et al., 1987), have issues with financial access (Caldwell, 1996; 2003; Mathews & Hughes, 2001; Morris, 2001), and tend to rely on informal resources such as religious institutions (Neighbors, 1985; Musgrave et al., 2002; Lincoln & Chatters, 2003), to name a few. However, though prior research has suggested many factors that may assist in understanding patterns of mental health care utilization among African American women, these studies

are few and limited in scope (Caldwell, 2003). Existing research has generally failed to identify consistent and specific barriers and incentives to seeking out professional psychological services and lack opportunities to elicit direct explanations (Timlin-Scalera et al., 2003) relative to the influences and internal processes motivating or hindering African American women from utilizing formal mental health care. The limitations of previous survey research speak to the need for interview formats that may provide an understanding of specific professional psychological help-seeking attitudes and behaviors, variables associated with such help-seeking, and examine the processes affecting decisions of whether or not to seek out mental health care services (Timlin-Scalera et al., 2003). Given the lack of research examining the professional psychological help-seeking attitudes of this population, as well as the need for more descriptive and comprehensive data in this area, at this point (Timlin-Scalera et al., 2003), a qualitative design was necessary to delve in depth into the complexities and processes affecting service utilization. Quantitative investigation cannot provide an

> understanding of human actions without understanding the meaning that participants attribute to those actions – their thoughts, feelings, beliefs, values, and assumptive worlds; the researcher, therefore, needs to understand the deeper perspectives captured through face-to-face interaction . . . the objective scientist, by coding the social world into operational variables, destroys valuable data by imposing her world on the subjects (Marshall & Rossman, 1999, p. 57).

The first step to understanding fully the issues pertinent to patterns of professional mental health care utilization among African American women is to speak directly to African American women (Suzuki, Prendes-Lintel, Wertlieb, & Stallings, 1999). In doing so, the results of this study indicate that while perceptions of mental health care is an important factor motivating and/or deterring African American women from seeking professional mental health care in instances of psychological distress, the interaction of many factors revealed themselves as significant to this complex and multifaceted picture. These women characterize counseling and/or therapy in a favorable manner, conclude that counseling/and or therapy would be or has been inappropriate for their needs.

The culmination and analysis of the emergent themes (*It Doesn't Work, My Way Works Fine, No More Than I Can Bear,* and *Community Perceptions*) suggest that heavily linked to both participants with and without a history of treatment and their appraisal of the relevance and efficacy of mental health services and thus the use of such services is the negotiation between symptomlogy and racial, cultural, and gender identity. Consistent with previous research (Morris, 2001), it was the general consensus, for example, that African Americans do not utilize mental heath services unless in instances of crises. However, those with a history of treatment found themselves, embarrassingly, making concessions in order to seek out this "last resort," in hopes of alleviating their anguish. Specifically, African American women are more inclined to seek formal care particularly in instances of depression or when "I can't figure it out by myself . . . I've tried everything else." Though African American cultural norms

are very specific about the instances in which mental health care should be utilized (severe psychopathology – psychosis), as these women exhausted all informal coping strategies, out of desperation, they turn to the mental health system for care.

Entering the mental health care system brings shame, fear, hesitancy, and doubt in the utility, trust in the cultural congruence of services provided, and the efficacy of treatment. They emphatically seek to avoid the stigma associated with mental health care and the perceived symptoms that constitute "illness" or "disorder." As such, once in counseling or therapy, they are driven away (premature termination) while those without a history of treatment allows their misconceptions of mental illness to deter them from ever seeking out needed help.

The context in which African American women are to develop an identity is a racist and sexist one (Shorter-Gooden & Washington, 1996). Their position on the racial, cultural, and gender identity continuum led participants away from professional psychological care. These women were led toward their relationships with and faith in God ("let go and let God"), to their communities and social networks, to seek refuge in their ability to whether the marginalization and oppression experienced as African American women ("Strong Black Woman"), and away from disloyalty and perceived European American cultural norms. They were taught that one's status as an African American woman brings with it certain inherent suffering. These women have learned from those around them that to experience, to various degrees, role strain, to feel tired, overworked, and

underpaid is to be African American and an African American woman in particular. One's inability to "get through" such circumstances is perceived as weak. To persevere in spite of their plight in American society is part of a legacy that they are proud of. They are taught early in life to rely on self, yet this perspective blurs their ability to observe the severity of their symptoms. They attempt desperately to uphold this position. Further complicating matters, is the process of comparing their own circumstances to those of other African American women for confirmation that their experiences and symptoms are normal, lead to further gaps in access as both the participants of this study and the women in their lives are unable to decipher the severity of their circumstances and when and if professional care is warranted (West et al., 1991). To endure an inordinate amount of suffering is to be a "Strong Black Woman." An image to model one's self after.

Among those who surrendered to the pain and suffering associated with their symptoms, in the end, all left their therapeutic experiences prematurely and with negative perceptions and what for them was further validation of the inappropriateness of this form of help ("I knew it . . . I don't know what I was thinking"). Irrespective of a history of treatment, all participants concluded that mental health treatment would/does inevitably end in poor outcomes (no relief).

Limitations

There are several inherent limitations within this study. In spite of the use of open-ended questions, the interview protocol led participants to attend and respond to particular aspects of their perceptions. As such, there may be countless elements that the interview guide did not address and thus may not have been discussed. Furthermore, qualitative research is inherently dependent on the openness and honesty of participants. In addition, as interviews were conducted and problems or issues arose with the interview protocol, which resulted in slight changes and/or additions to the interview guide, this process may have created some inconsistency across interviews.

Bias in data interpretation is an often-cited potential problem in qualitative research as data are open to multiple interpretations. I addressed this problem, however, by providing respondents with an opportunity to review and/or make changes to their transcriptions to confirm the accuracy of the data. Once the interviews were analyzed, my interpretations were sent back to each participant so that they were able to comment on any errors of fact and/or to note any inaccuracies in the interpretation of their responses. I also requested that a doctoral student of psychiatric epidemiology familiar with the literature and a colleague in marriage and family therapy proficient in qualitative research methodology provide feedback on the emerging findings. Further, I supported my findings by incorporating an analysis of my notes. These notes provided background information and context for interpreting the transcripts during analysis.

Another issue is the race, ethnicity, and culture of those involved in analyzing the data emanating from the present study. One limitation spoken of in qualitative research is the range of interpretations possible due to cultural differences. However, to safeguard against this possible limitation, all involved in assessing the data were African American. This contributed to the accuracy of interpretations, as these individuals were most likely to be attuned to subtle nuances in African American communication and culture.

To address issues of the generalizability of the findings (though technically qualitative research is not concerned with generalizability), I attempted to recruit a diverse sample and ensured that no respondents were associated in any way. As generalizability relates to qualitative research, "Whether they (findings) hold in some other context, or even in the same context at some other time, is an empirical issue, the resolution of which depends upon the degree of similarity between earlier and later contexts" (Lincoln & Guba, 1985, p. 316). I attempted to provide a detailed description of the context of the investigation so that readers are able to assess the similarities and differences between this study and their own (Lincoln & Guba, 1985). I also developed an audit trail of materials that documented how the study was conducted including what was done, when, and why (Ary et al., 1996). The trail incorporated information about participant selection, data collection and analysis, etc. (Merriam, 1995, 1998). Using the audit trail as a guide, my colleague from marriage and family therapy proficient in qualitative methodology examined the study to attest to the dependability of the procedures and to examine whether the findings were reasonably derived from

the data (Lincoln & Guba, 1985). However, despite the dependability of procedures, intrinsic in qualitative research is the difficulty of replication as there are many issues that may arise making it difficult to stick closely to planned procedures, etc. In addition, "Clearly, replication of a qualitative investigation will not yield the same results (as it might in quantitative research). Rather, both sets of results stand as two interpretations of the phenomenon" (Merriam, 1988, p. 56).

An additional issue regarding the use of constant comparative methods of data analysis is the potential for individual differences among participants to have been dismissed once analysis began. In this approach, distinct concepts reflecting each interviewee's subjective beliefs were collapsed into increasingly more general categories. Thus, what was characteristic of most participants is what is articulated while alternative responses may have received limited attention in the reporting of results.

The data analysis procedures were primarily based on an individual approach with the assistance of persons well versed in the area and in qualitative research methodology and analysis. However, inherent biases (mono perspective) exist in utilizing individual methods. A collaborative format by a research team allows for a research team to be involved in conceptualization of the study's goals and participation at multiple stages. In the analysis phase, team members would be able to argue until consensus.

Another limitation of the present study was that research participants were ultimately self-selected. All interviews were conducted primarily in the Northeast region of the country, though not all participants originated from this area. In addition, the standard used for selecting participants may have contained some bias in that interviewees where known to other African American women (colleagues) who were dedicated to the recruitment of participants to assist in the successful completion of the researcher's dissertation and degree. Participants were willing to participate conceivably for the purposes of the completion of this dissertation and the researcher's degree as well, thus possibly skewing the sample toward women who believe in psychological and educational research, in helping other African American women, etc. The participants of this study may consequently represent a certain group of African American women dedicated to contributing to the success of other individual African American women and thus the group as a whole. Further, the participants may have picked up clues regarding the goal of the study and may have consequently altered their responses to support or disaffirm their perceptions of what they thought the researcher sought out to find.

While the present study included a generally diverse set of respondents (i.e., SES, income bracket, level of education, employment status, occupation, religion, children, marital status, etc.), additional sources of data might have further strengthened the study (quantitative). The retrospective nature of many of the interview questions with respondents who possessed a history with receiving treatment raises some concern about the possible effects of selective attention

and gaps in their memory of services received. Furthermore, all respondents with a history of treatment were treated by European American practitioners. This is a weakness as there were no participants who were able to offer their experiences in working with an African American mental health professional. Thus there was no way of contrasting similarities and differences in working with African American and European American mental health professionals.

Lastly, the participants of this study were not part of an identified clinical population. As such, their attitudes and perceptive may not necessarily pertain to African American clients who are actually experiencing problems that might require professional psychological attention.

Implications for Practice

The major implication of this study was that heavily linked to participants' appraisal of the relevance and efficacy of mental health services and thus help-seeking attitudes is the interactions of various factors emanating from one's location on the racial, cultural, and gender identity continuum. Because professional psychological help-seeking is an invaluable form of assistance in instances of psychological distress, access to these services is a critical resource for addressing the personal and emotional distress of African American women and thus contributing to mental health and well-being and reducing national health care costs (Addis & Mahalik, 2003). Improving the relationship between the mental health care establishment and African American women is one way to improve the lives of these women. As such, the current investigation may prove

useful in elevating the awareness of obstacles facing African American women in need of mental health services.

Reducing the influence of restrictive racial, cultural and gender norms may increase the willingness of African American women to seek and receive mental health treatment. Approaching the issue of divergent mental health care service utilization from this perspective may offer some direction in order to begin to develop new and innovative strategies for reducing the stigma associated with treatment. To make the link between service providers and potential clients/patients, this population must become more appropriately informed about what counseling and/or therapy is, what the process "looks like" (i.e., self-disclosure, homework, etc.), how these services can help, how long the process may take, thus challenging misconceptions and anticipated risks associated with these services, increasing the likelihood of service utilization. This approach aims to reduce fears related to the therapeutic process, while addressing the public's sense of anticipated risk and utility (Vogel & Wester, 2003).

To create a more approachable system geared toward the characteristics of this population, some practical strategies might be to create relationships between the church and services providers, have the mental health establishment develop partnerships with cultural organizations, and developing magazine advertisements (i.e., *Essence* magazine). Having famous and influential people (African American women) associated with traditional racial, cultural, and gender norms possessing a history of treatment due to personal and emotional distress to serve as examples of adaptive help-seeking (Timlin-Scalera

et al., 2003). Simultaneously, it is imperative to raise awareness about specific racial, cultural, and gender norms that may be maladaptive and prevent access. Mental health care professionals must become well informed regarding the barriers to help seeking and become able to effectively address these dynamics in their work with African American women.

Further, the mental health establishment must more obstinately work toward developing strong relationships with the African American church as religion and spirituality has historically and continues to play a significant role in the mental health and well being of African Americans (Richardson & June, 1997). Through close ties with the African American church, mental health care professionals may begin to reach those in need who may not have been accessible without the assistance and support of ministers and other church leaders. Providers may begin to play a more active role through prevention programs, workshops, and when necessary, treatment. Developing these partnerships may encourage church officials to consider formal counseling and/or therapy and thus refer their parishioners to mental health professionals in instances of psychological distress. From the potential counselee/patient perspective, "A person is more likely to participate in counseling and feel more comfortable with a counselor who has the respect and trust of his or her pastor and church community" (Richardson & June, 1997, p. 160). In addition, it is recommended that mental health professionals become more willing and able through training to integrate religious and spiritual aspects in the therapeutic process (Richardson & June, 1997). Providers must be prepared to explore the

role that spirituality and religion plays in the lives of their clients/patient in addition to expressing a true respect and understanding of the worldview that stems from these beliefs (Richardson & June, 1997).

From the education and training side of the issue, given the distinctiveness of the social position of African American women in American society and the experiences that this location provoke, traditional conceptualizations of mental health and illness that work for European Americans and other women are improbable to work for African American women (Brown, 2003). The paradigms from which practitioners are taught to render services are inadequate in explaining and addressing the unique and complex issues and concerns of this population. As such, in addition to the teaching of alternative paradigms that are more consistent with the racial, cultural, gender issues significant to African American women, there should be greater efforts to recruit African Americans in the mental health field. Many of the women in this study correctly assumed that the mental health establishment is largely comprised of European American practitioners. As there are still too few African American mental health providers who have similar cultural roots and have experienced, to varying degrees, the effects of racism, sexism, and the impact of Eurocentric thinking on their psychosocial development (Morris, 2001). This experience, given the proper attention and training, can be drawn from to assist in the formation of appropriate conceptualizations of the presenting concerns of this population. As alluded to above, European American students must be educated in such a way that

removes "multicultural and diversity issues" from the traditional practice of observing this area as a "particular clinical or research interest" to an inherent part of professional development and practice. Programs must make the commitment to move their students toward the "process" of developing into multiculturally competent practitioners. Training programs must create an atmosphere of learning in which an acceptable part of training is to go through the process of becoming a competent professional through self-discovery and understanding. "A therapist can only move their patients as far as they themselves have gone" (I. Watkins-Northern, personal communication, April 22, 2003). Students and faculty alike must be challenged to air their biases and misconceptions. They must be confronted and challenged to observe from where their beliefs emerged. Process groups should be implemented to explore and discover the motivations for their conceptualizations of clients and their presenting concerns. These groups should allow for open and candid discussion and challenges. In doing so, practitioners and researchers become intrinsically aware and should be taught to question their own motivations, responses, reactions, etc. To do so will bring about the more appropriate rendering of services and in time, higher rates of service utilization.

Finally, there should be a greater effort on the part of the American Psychological Association to commit to moving programs toward a standard of training whereby students graduate from their programs with a more principled, moral, and ethical standard of practice. Specifically, the Ethical

Principles of Psychologists and Code of Conduct does not necessarily equate to an appropriate standard of practice. Simply adhering to these standards, from one's own interpretations, does not by design give rise to adequate services. More must be done than the education of the ethics standards and the practice of the application of various ethical decision making trees to scenarios. While important, this standard practice is simply a piece of the whole. Without the in-depth inner exploration, challenge, and consistent change, such practices and knowledge are ineffective ensuring equitable service delivery and carefully planned research endeavors.

Implications for Future Research

Based on the findings of this study, the following list is proposed concerning direction for future exploration.

1. Additional qualitative research should be devoted to further exploration to clarify issues pertinent to patterns of mental health service utilization among African American women from other regions of the country.
2. Further qualitative research should be conducted to illuminate issues pertinent to patterns of mental health service utilization among other women of color. The findings emanating from the present study could be compared to those of other women of color, thus providing a better picture of the factors affecting service utilization to improve access to mental health care among minority women.

3. Qualitative research should be devoted to the study of help-seeking among African American women as this ability is important to resolving numerous problems in living (Addis & Mahalik, 2003).
4. Additional research attention should be given to investigating perceptions of the structural and cultural factors that mediate professional psychological help-seeking attitudes and behavior in African American women.
5. Further qualitative research should be conducted to examine the processes affecting adherence to cultural and gender norms and their relation to professional psychological help-seeking attitudes and behavior (Addis & Mahalik, 2003).
6. Although the present investigation represents an initial step toward expanding our knowledge and understanding of the processes affecting professional psychological help-seeking behavior among African American women, other segments of this group should be addressed as well (i.e., lesbians, women with disabilities, women with chronic illnesses).
7. Given the crisis in which African American men are in and the low rates of service utilization, future investigation should be geared toward understanding the factors which motivate or deter African American men from seeking out formal mental health care as well as the current strategies used to address and manage in instances of personal and emotional distress.

8. Empirical investigation that examines the issues arising in individual versus team approaches to qualitative research and data analysis in particular. In addition, empirically testing various strategies to address biases within individual and team approaches to qualitative research should be examined.
9. Further research toward understanding the role of social networks in encouraging or disparaging the use of mental health care and generally the effectiveness of and issues arising in social support networks as a source of mental health and well-being of African American women.
10. Future research endeavors should be directed toward exploring and contrasting the experiences of African American women who have been treated by African American counselors or therapists in comparison to those who were treated by European American counselors or therapists.

Summary

In summary, the purpose of this study was to explore the issues utilizing qualitative methodology to the issues significant to patterns of mental health care service utilization. Though attempts have been made to uncover pertinent issues affecting the professional psychological help-seeking behaviors of the population "at large," exploration relative to certain sectors of the population remains deficient. One particular group in need of exploration

devoted to understanding professional psychological help-seeking attitudes is African American women (Mays, 1995; Mays & Comas-Diaz, 1988). Given the magnitude of stress that African American women experience increases their vulnerability for developing psychological illness (Corbett, 1998). However, it remains that this population continues to avoid professional psychological help in instances of personal and emotional distress. As such, it is critical that investigation in this area take place in order to develop ways of making access as uncomplicated and painless in light of the anguish persons who enter the system are likely to present.

Eight African American women between the ages of 21 – 55 years participated in this qualitative study. Semi-structured interviews were conducted to gather the qualitative data. As a result of an inductive analysis of the data emanating from these interviews, four themes emerged: *It Doesn't Work, My Way Works Fine, No More Than I Can Bear,* and *Community Perceptions*. The first theme, *It Doesn't Work,* describes the subjective views of the women regarding professional psychological care. Within this theme, there were 3 sub-themes. They were "Therapy's Good But Not for Me," "It's Not Reasonable," and "Black Problems." The second theme, *My Way Works Fine*, illustrates the manner in which these women go about promoting and preserving their psychological well being in opposition to making use of counseling or therapy in instances of psychological distress or in light of perceived non-benefit from past experiences with mental health services. Within the second theme, there were also 3 sub-themes. Specifically, they were "I Handle It On My Own," "Look

Around You," and "My Circle." The third theme, *No More Than I Can Bear,* illustrates the women's articulations of the role of spirituality and religion in shaping their understanding of emotional and psychological distress and their faith as a way of "getting through." The fourth theme, *Community Perceptions*, describes respondents' observations of the general stance of the African American community and its influence on their willingness to make counseling or therapy an option for assisting in attending to their problems and concerns.

The integration of these themes and sub themes create an image implicating that heavily linked to participant's (both who have and have no history of treatment) appraisal of the relevance and efficacy of mental health services and thus help-seeking attitudes is the interactions of various factors emanating from one's location on the racial, cultural, and gender identity continuum. As such, the major practical implication directs service providers to become proficiently aware of the racial, cultural, and gender norms that may be maladaptive and prevent needed access to treatment. Mental health care professionals must become well informed regarding the barriers to help-seeking and become able to effectively address these dynamics in their work with African American women. Given the oppressive, inequitable, detrimental circumstances that occupy African American women in American society, it is necessary, urgent, and vital to the physical and mental health and well being of this population to surmount barriers to access. To do so means a substantial effort on the part of the mental health establishment to create a system of care, providing

mental health services that are high quality, equitable, approachable, and geared toward the racial, cultural, and gender characteristics of this population.

APPENDIX A

(Oral Consent by Phone) *"More Than I Can Carry"*: African American Women's Mental Health Project

Thank you for your interest in our project. The purpose of this study is to examine African American women's perceptions of mental health treatment. Generally, mental health services are not relied on by the African American community as a means of coping with stressful life events and circumstances despite high levels of stress and stress-related health problems. So it's important for the mental health community to identify adequate means of addressing the unique concerns of this community. So basically we're interested in exploring the range of thoughts and feelings held by African American women about mental health treatment. We would like to examine perceived barriers and incentives to seeking out mental healthcare, the kind of problems considered appropriate for this form of help, and whether or not in your opinion, there is a need for changes that would better service your emotional and psychological needs or make counseling or therapy a more practical option.

If you voluntarily choose to participate, you will 1st be asked to respond to a series of questions such as your current age, dating/marital status, income, level of education, etc., designed to be used as a screening tool for obtaining a diversity of participants. I do not anticipate that participation in this study will be associated with any significant risks to you. However, as many of the screening questions touch upon some personal information about yourself, you may experience some temporary discomfort when answering questions. However, you are free to refrain from answering any questions during the telephone screening or to withdraw your participation completely at any time without penalty. Your responses to the screening questions will be kept confidential. Under no circumstances will you be identified in connection you're your responses. The total amount of time required to complete the telephone-screening questionnaire is 10 minutes.

Following the completion of the screening, if you are asked to participate and you agree, on the date of your scheduled interview, you will be asked to complete 1 demographic questionnaire and an individual interview about your views, experience, and understandings of counseling and therapy. The total amount of time required to complete both the survey and interview portions of this study is about 1-½ hours.

If you have questions regarding the study, please contact Paula Mitchell directly at (202) 294 – 5744 or blackwomen75@yahoo.com. If other questions or concerns are raised regarding your rights as a participant, you can directly the Chair of Michigan State University's Human Subjects Review Committee, Dr. Ashir Kumar by phone at (517) 353-3262, by fax at (517) 432-4503, or by mail at 202 Olds Hall, Michigan State University, East Lansing, MI 48824-1046 for additional information or consultation.

Do you agree to participate? YES NO

APPENDIX B

Telephone Screening Sheet

How would you describe your ethnic identity? _____

How old are you? _____

Partner Status

___ Single, not dating
___ Single, dating several persons
___ Partnered, not married
___ Engaged
___ Separated
___ Married
___ Divorced
___ Widowed

Current living/residential status

___ living at parent's home
___ live in residence hall
___ live with others in rented apartment or home
___ live alone in rented apartment or home
___ own home
___ other (please specify): _____

Who lives with you? Give numbers when appropriate

___ children
___ spouse
___ mother
___ father
___ grandparent
___ sister
___ brother
___ mother-in-law
___ father-in-law
___ brother-in-law
___ sister-in-law
___ niece
___ nephew
___ cousin
___ aunt
___ uncle
___ friend
___ other

Income

___ $0 to 9,999
___ $10,000 to $15,999
___ $16,000 to 25,999
___ 26,000 to 35,999
___ $36,000 to 49,999
___ $50,000 or above

Highest level of education

___ High school graduation/diploma
___ Vocational/technical degree
___ Two-year (Associate's) college degree
___ Some college, no degree, not currently enrolled
___ Some college, no degree, currently enrolled
___ Bachelor's (4-year) degree
___ Some graduate work, no degree, not currently enrolled
___ Some graduate work, no degree, currently enrolled
___ Graduate degree (MBA, Ph.D., M.D., etc.)

Occupation: _____

Mailing Address: _____

APPENDIX C

Interview Confirmation Letter

Paula Mitchell
5555 16th St. N.W.
Washington, DC 20000

August 18, 2003

Sharon Mitchell
5603 Hickory Lane
African American, TX 22222

Dear Ms. Mitchell:

Thank you for agreeing to participate in the African American Women's Mental Health Project. This letter serves to confirm our telephone conversation. The purpose of this study is to broadly explore the range of definitions, thoughts, feelings, and views held by African American women relative to professional mental health treatment. The University Committee on Research Involving Human Subjects and the Department of Counseling, Educational Psychology, and Special Education at Michigan State University had approved the project. As discussed, the interview is scheduled to take place on:

Date: August 25, 2003
Time: 6:30 pm.
Place: Respondent's address

The interview will be audio recorded as discussed in our telephone conversation; however, the results of your participation will be confidential and will not be released in any individually identifiable form without your consent, unless otherwise required by law. Pseudonyms will be used in the presentation and analysis of all findings to insure your confidentiality.

As discussed during our telephone conversation, once your interview has been transcribed, the transcribed interview will be sent back to review and/or make changes to the transcriptions to confirm the accuracy of the data. In addition, once the transcript has been analyzed, my interpretations will be sent back to you so that you are able to comment on any errors of fact and to note any error in interpretation of your responses.

Please reserve 90 minutes for this interview. If in the days leading up to our scheduled interview you find that this day and time is inconvenient, you have additional questions or concerns, or that you are no longer interested in participating, please call (202) 294 – 5744 or blackwomen75@hotmail.com to reschedule or cancel the interview or if you have any questions. If other questions or concerns are raised regarding your rights as a participant, you can directly the Chair of Michigan State University's Human Subjects Review Committee, Dr. Ashir Kumar by phone at (517) 353-3262, by fax at (517) 432-4503, or by mail at 202 Olds Hall, Michigan State University, East Lansing, MI 48824-1046 for additional information or consultation. Thank you so much for your interest and time and I look forward to meeting with you.

Sincerely,

Paula Mitchell

APPENDIX D

"More Than I Can Carry": African American Women's Mental Health Project

Thank you for your expressed interest in this research project. The purpose of this study is to examine African American women's perceptions and understandings of mental health treatment. We are interested in exploring the range of thoughts, feelings, and ideas held by African American women about mental health treatment. We would to examine perceived barriers and incentives to seeking out counseling and therapy, and the kind of problems considered appropriate for this form of help.

If you choose to participate, you will be asked to complete 1 demographic form and to be interviewed about your views, experience with, and understanding of counseling and/or therapy. The total amount of time required to complete participation in this study is approximately 90 minutes.

Participation in this study is completely voluntary. You are free to refrain from answering any questions during the interview or to withdraw your participation completely at any time without penalty.

I do not anticipate that participation in this study will be associated with any significant risks to you. However, as some interview questions may touch upon areas of past and current life or relationship dissatisfaction and your current methods of managing life stressors, you may experience some temporary discomfort when answering questions.

Although the interview portion of this study will be audio-recorded, you will NOT be identified by name on the tape itself or any of the survey measures you complete. A three-digit research identification number will be used for these purposes in order to maintain your confidentiality and to protect your privacy to the maximum extent allowable by law. Under no circumstances will you be identified by name in connection with any subsequent reporting of the findings. You will be given a pseudonym for the purpose of the presentation of the data.

If you have questions regarding the study, please contact Paula Mitchell directly at (202) 294 – 5744 or blackwomen75@yahoo.com. If other questions or concerns are raised regarding your rights as a participant, you can directly the Chair of Michigan State University's Human Subjects Review Committee, Dr. Ashir Kumar by phone at (517) 353-3262, by fax at (517) 432-4503, or by mail at 202 Olds Hall, Michigan State University, East Lansing, MI 48824-1046 for additional information or consultation.

If you agree to participate in this study, please PRINT and SIGN your name in the appropriate spaces below. Also, please enter today's date in the appropriate space. You may keep the attached copy of this form for your personal records.

I agree to participate in this study directed by Paula Mitchell as described above. I have read the above information and voluntarily agree to participate.

_____	_____	_____
PRINT your name here	SIGN your name here	Today's date

APPENDIX E

Demographic Questionnaire

Directions: Please give the following information by checking the correct items or by directly entering requested information.

Age: _____

Your current dating/marital status (check all that apply):

___ Single, not dating
___ Single, dating several persons
___ Single, in a committed relationship
___ Engaged
___ Separated
___ Married
___ Divorced
___ Widowed

Who lives with you? Give numbers when appropriate

___ children
___ spouse
___ mother
___ father
___ grandparent
___ sister
___ brother
___ mother-in-law
___ father-in-law
___ brother-in-law
___ sister-in-law
___ niece
___ nephew
___ cousin
___ aunt
___ uncle
___ friend
___other

Indicate your current living/residential status (check one):

___ living at parent's home
___ live in residence hall
___ live with others in rented apartment or home
___ live alone in rented apartment or home
___ own home
___ other (please specify): _____

Indicate your socioeconomic bracket (check one):

___ lower class
___ working class
___ middle class
___ upper middle class
___ upper class

Indicate your income bracket (check one):

___ $0 to 9,999
___ $10,000 to $15,999
___ $16,000 to 25,999
___ 26,000 to 35,999
___ $36,000 to 49,999
___ $50,000 or above

Highest level of education (check one):

___ High school graduation/diploma
___ Vocational/technical degree
___ Two-year (Associate's) college degree
___ Some college, no degree, not currently enrolled
___ Some college, no degree, currently enrolled
___ Bachelor's (4-year) degree
___ Some graduate work, no degree, not currently enrolled
___ Some graduate work, no degree, currently enrolled
___ Graduate degree (MBA, Ph.D., M.D., etc.)

Employment Status

___ Work, full time
___ Work, part time
___ Not Working
___ Looking for work
___ Work & student
___ Student
___ Homemaker
___ Retired
___ Other _____

Describe your current occupation: _____

FATHER'S highest level of education

___ Some high school
___ High school graduate/diploma
___ Vocational/technical degree
___ Two-year (Associate's) college degree
___ Some college (no degree)
___ Four-year (Bachelor's) college degree
___ Some graduate work
___ Graduate degree (MBA, Ph.D., M.D., etc.)
___ Don't know

Enter your **FATHER'S** occupation*: _____

MOTHER'S highest level of education

___ Some high school
___ High school graduate/diploma
___ Vocational/technical degree
___ Two-year (Associate's) college degree
___ Some college (no degree)
___ Four-year (Bachelor's) college degree
___ Some graduate work
___ Graduate degree (MBA, Ph.D., M.D., etc.)
___ Don't know

Enter your **MOTHER'S** occupation*: _____

* If retired, indicate most recent occupation for each parent

Identify the people who lived in your childhood home. Give numbers when appropriate.

___ brother-in-law
___ mother
___ father
___ grandparent
___ sister
___ brother
___ family friend
___ sister-in-law
___ niece
___ nephew
___ cousin
___ aunt
___ uncle
___ other

Enter your childhood religious affiliation:

___ Catholic
___ Atheist
___ Baptist
___ Methodist
___ Islam
___ Black Muslim
___ Lutheran
___ Other: _____
___ Church of Christ
___ Episcopalian
___ Jewish (Hebrew/Israelite)
___ Jehovah's Witness
___ Protestant
___ Buddhist
___ African Methodist Episcopal

Enter your current religious affiliation:

___ Catholic
___ Baptist
___ Methodist
___ Islam
___ Black Muslim
___ Lutheran
___ Pentecostal
___ Church of Christ
___ Episcopalian
___ Judaism
___ Jehovah's Witness
___ Pentecostal
___ Buddhist
___ Other: _____

Indicate a description of your childhood home:

___ Apartment
___ House (rented)
___ House (owned)
___ Town home
___ Trailer
___ Condominium
___ Other: _____

Indicate a description of your childhood neighborhood:

___ Urban
___ Rural
___ Suburban

What percentage of your childhood friends was African American?

___ 0 - 10%
___ 11 - 25%
___ 26 - 50%
___ 51 - 75%
___ 76 - 100%

What percentage of your current friends is African American?

___ 0 - 10%
___ 11 - 25%
___ 26 - 50%
___ 51 - 75%
___ 76 - 100%

APPENDIX F

Interview Guide

I. OK, tell me a little bit about your family (*immediate family*?)
   a. Who's in your family?
   b. Are your parents married? Were your parents ever married? Did your parents divorce?
   c. How is your relationship with your mother/father? OR Describe your relationship with your mother/father.
   d. How often do you talk to your parent/s?
   e. Do you talk about personal concerns? Are their things that it would be hard to talk to them about? What kind of support do you get from them? What don't you get that you feel you need from them?
   f. If you were an unhappy or upset as a child, what would you do? EXAMPLE: How did your parents respond (when you were emotionally or physically hurt)? Did you get what you needed? What would have liked to have received from them?
   g. How do you think your experiences growing up with your family have influenced your relationships with people outside your family?

II. Would you describe yourself as a spiritual or religious person? What does your relationship with God/Allah/the Spirit/Jesus, etc., provide you with?

III. Are their times in your life when you feel stressed, sad, depressed, unhappy, alone, and hopeless? Can you describe some instances? (Examples)
   a. What do you do to feel better or to manage and get through your problems?
   b. Who and where do you go to deal with your problems?
   c. If necessary, are you more likely to go to other people or do you tend to deal with your problems on your own?
      i. IF SOMEONE ELSE IS APPROACHED:
         1. Who do you normally approach to discuss your problems, feel supported, and look for help in addressing your concerns (EX.AMPLE Friends, people from church, etc.)
         2. Do you discuss personal matters with your close friends? Are there things you wouldn't talk about or that would be difficult talk about? (EXAMPLE)
         3. Based on your response, do you prefer those individuals to be direct and tell you how to solve your problems or do you prefer to be assisted in your decision-making or given many directions and avenues to possibly pursue?
      ii. Where did you learn to handle your problems this way? What role did your mother, grandmother, aunts, female cousins, or other important women play? Do you believe you have carried these strategies on in your adulthood?

IV. When I say "mental health treatment" or "counseling and therapy" what comes to mind? What do the words counseling and therapy mean to you?
   a. How do you feel about counseling or therapy?
   b. What information have you received in the past about mental health treatment? Where did this information come from?
   c. Have you ever been to counseling and therapy?
      i. IF YES:

1. Under what circumstances?
2. Was it beneficial?
3. Would you do it again?

ii. IF NO:

1. Under what circumstances would you seek out counseling for yourself, if at all? (EXAMPLES, why, why not)
2. IF THERE ARE INSTANCES: What would be the benefit?

d. If you went to counseling and therapy, would you openly disclose this to friends and relatives?

i. IF NOT, WHY NOT? (Fear of disclosure, costs, etc.)
ii. IF NOT: In your opinion, what benefits might you receive from participating in counseling and therapy?

V. How do you think the African American community generally views mental health treatment? In your opinion why would others look to mental health treatment? Many don't use, why do you think that is?

APPENDIX G

PAULA MICHELLE MITCHELL

EDUCATION

1999-2004 **Michigan State University** East Lansing, MI
Ph.D., Counseling Psychology

1997-1999 **Howard University** Washington, DC
M.Ed., Counseling Psychology

1993-1997 **University of Oklahoma** Norman, OK
BA, Psychology

DISSERTATION

Title, A Qualitative Analysis of Professional Psychological Help-Seeking Attitudes Among African American Women, chaired by Lee June, Ph.D. The purpose of this qualitative study was to broadly explore the issues significant to professional psychological help-seeking attitudes and behavior among African American women.

APA ACCREDITED PRE-DOCTORAL INTERNSHIP

Psychology Intern, **Howard University Counseling Service** under the Guidance of Nickole Scott-Conerly, Ph.D., August 2003 – Present. Duties: Individual and group counseling and psychotherapy; psychodiagnostics; intake interviewing; vocational and career counseling; community and university outreach; instruction of a microcounseling lab for 2nd year Clinical Psychology students; rotational placements with the Child Guidance Clinic of the Superior Courts of the District of Columbia conducting forensic psychological evaluations and with the Psychiatric Unit of Howard University Hospital interviewing psychiatric patients and going on rounds with the psychiatry team; Out-placement referral and community liaison.

POST-DOCTORAL FELLOWSHIP

Post-Doctoral Fellow in Forensic Psychology **(*Adult track*), The Law and Psychiatry Program at the University of Massachusetts Medical School (UMMS),** directed by Ira Packer, Ph.D., September 2004 – August 2005. Receive applied clinical experience including inpatient work in a maximum-security forensic hospital (Bridgewater State Hospital), a Department of Mental Health state hospital (Worcester State Hospital), and court clinics. Fellows perform or participate in performing forensic evaluations such as Competency to stand trial, Criminal responsibility, Future violent (dangerous) behavior, Sentencing, and Civil commitment. Fellows receive exposure to and experience in expert testimony and forensic consultation and participate in a Forensic Psychology/Psychiatry Seminar, a Landmark Mental Health Law Case Seminar, and a Law-Psychiatry Case Conference. Fellows develop or participate in ongoing research projects on various topics or problems related to mental health law or forensic clinical psychology. Fellows receive training and certification as Designated Forensic Professionals able to perform evaluations for criminal courts.

Project Coordinator, **Community Research Group of the Mailman School of Public Health at Columbia University and the New York State Psychiatric Institute** under the Guidance of Mindy Fullilove, M.D., Understanding the Transmission of Urban Decay Along a Transportation Route: A Comparison of Two Transects in Newark, NJ, February 2003 – July 2003. Duties: Responsible for supervising research assistants and tasks; coordinating and making arrangements for project planning meetings; overseeing and preparing all necessary project progress and implementation reports jointly with project staff; arranged production schedules; identified consultancy needs and assisted in the identification, selection and recruitment of consultants; assisted in collecting and maintaining data.

Ethnographer, **Research Foundation for Mental Hygiene** under the Guidance of Carol Caton, Ph.D., Peer Support Project, September 2002 – February 2003. Duties: Collected, recorded, and analyzed qualitative data related to the utility of Peer Support Programs designed to address the unique and complex issues and concerns of individuals post initial crisis treatment for psychosis and comorbid substance related disorders and the life context in which access to treatment occurs.

Research Assistant, **Michigan State University** under the guidance of Frederick G. Lopez, Ph.D., Department of Counseling, Educational Psychology, and Special Education, Attachment Research Team, January 2001 – Present. Duties: Assisted in the development of all phases of our current qualitative young adulthood study, including refining research questions, developing interview protocol, selecting the target population, designing and piloting interview questionnaire, conducting interviews, and analyzing data through the use of Consensual Qualitative Research methods (Hill, Thompson, & Williams, 1997)

Graduate Assistant, **Howard University** under the guidance of Veronica G. Thomas, Ph.D., Human Development and Psychoeducational Studies, Psychology of African American Women Project, October 1998-1999. Duties: Conducted an extensive literature review for the development of an annotated bibliography on books in psychology and selected related disciplines on African American Women. Responsible for the supervision of undergraduate assistants.

Consortium of Universities Research Fellow, **Department of Defense Education Activity** under the guidance of Ray Perez, Ph.D., 1997-1998. Duties: Conducted a comprehensive literature review on Instructional Design Models to ascertain their relevance for infusing technology into the classroom for President Bill Clinton's Presidential Technology Initiative

Research Assistant, **University of Oklahoma Health Science Center, Department of Psychiatry and Behavioral Sciences** under the guidance of **Rachel Ashby, M.Ed.,** "Western Village Student Task Force" (pilot study), 1996-1997. Duties: Implemented a violence prevention program ["Western Village Student Task Force" (pilot study)] to assist children to actively construct functional approaches geared toward breaking the current cycle of violence through personal experiences in low socioeconomic schools within the Oklahoma City Public School System

Research Assistant, **University of Oklahoma Health Science Center, Department of Psychiatry and Behavioral Sciences** under the guidance of Rachel Ashby, M.Ed., "I Am Special" Self-Esteem Enhancement Program, 1995-1996. Duties: Presented weekly presentations ("I Am Special" Self-Esteem Enhancement Program) directed toward enhancing the emotional competence of elementary age children in low socioeconomic schools within the Oklahoma City Public School District. Conducted literature reviews and data input.

CLINICAL EXPERIENCE

***Counseling Psychology Advanced Practicum Student*, Community Mental Health of Eaton County** under the supervision of Gilman Schmidt, Ph.D., Charlotte, MI, January 2002 – July 2002. Duties: Conducted structured clinical interviews, mental status exams, and weekly individual and couples short-term and long-term psychotherapy with a range of clients suffering cognitive and emotional impairments including mood, personality, anxiety, and substance related disorders utilizing cognitive behavioral therapy interventions.

***Counseling Psychology Practicum Student*, Michigan State University Counseling Center** under the supervision of Eleanor Bossi, Ed.D, East Lansing, MI, August 2000 – May 2001.Duties: Assessed and diagnosed college students with personal and career issues by conducting clinical interviews and psychological testing. Provided short-term and long-term psychological treatment.

***Masters of Education Graduate Student Clinical Counseling Intern*, Afro-American Counseling Psychotherapy Institute, Inc., Graduate School Outreach Counseling Clinic** under the supervision of Roosevelt Martin Johnson, Ph.D., Washington DC, May 1998 - September 1998. Conducted individual, family, couples, and group therapy with court mandated clients by the Superior Courts of the District of Columbia and voluntary individuals with impairments ranging from personality, mood, and addictive disorders utilizing cognitive, solution oriented, and brief therapy techniques. Assisted in the development of professional seminars and workshops on conflict resolution and anger management and conducted anger management counseling with students diagnosed with ADHD, Oppositional Defiant, and Conduct Disorder within the DC Public School System. Co-led therapy groups with teens.

***Substance Abuse Prevention Education Counselor*, Myrtilla Miner Elementary School** under the guidance of Sheila Holt, M.Ed., Washington DC, June 1998-August 1998. Duties: Fostered the development of positive self-esteem through values clarification and peer mediation through the arts and humanities.

***Mental Health Assistant*, Griffin Memorial Mental Hospital**, Norman, OK, September 1996-February 1997. Duties: Recreational counseling and supervision; monitored the behavior of assigned psychiatric patients and was responsible for general care and charting.

***Crisis Intervention Counselor*, #NYNE Crisis Line**, Norman, OK, September 1996-January 1997.Duties: Through active listening, reassurance, and goal setting, provided assistance in developing choices in resolving crisis as well as provided direction into appropriate options and resources; made routine referrals and maintained contact with area counselors, social workers, and other social services.

***Counselor*, Juvenile Services of Norman**, Norman, OK, August 1995-September 1996. Duties: Employed play therapy techniques in working with battered and sexually abused children under the supervision of specialized therapists.

***Certified Nurse Assistant*, Rosewood Manor Living Center**, Norman, OK, May 1995-September 1995. Duties: Assisted with the care of psychiatric, functionally disabled, and aged and chronically ill patients under the supervision of Nurses and Physicians; provided general care and charting.

TEACHING EXPERIENCE

***Instructor*, Michigan State University**, East Lansing, MI, September 2000 - May 2002. Duties: Instructed two TE 250 Human Diversity, Power and Opportunity in Social Institutions courses. Supervising Faculty, Christopher Wheeler, Ph.D. Responsible for developing syllabi, lectures, class activities, projects, exams, choosing reading and other course materials.

***Instructor*, Michigan State University**, East Lansing, MI, September 1999 - May 2001. Duties: Instructed a CEP 261 Substance Abuse course. Received instructional design training under Stephen Yelon, Ph.D. Responsible for developing syllabi, lectures, class activities, projects, exams, and other course materials.

PUBLICATIONS

Lopez, F. G., Mitchell, P., & Gormley, B. (2002). Adult attachment orientation and college student distress: Test of a mediational model. *The Journal of Counseling Psychology,* 49, 460 – 467.

Thomas, V., Braithwaite, K., & Mitchell, P. (2001). *African American women: An annotated bibliography.* Westport, CT: Greenwood Press.

CONFERENCE PAPERS AND PRESENTATIONS

Scott-Conerly, N., Nickens, E., Brown, A., Coleman King, M., Mitchell, P. (2004). Innovative Outreach Programs. The National Association of Student Affairs Professionals. The Golden Jubilee 1954 – 2004: Student Affairs Professionals: Transcending All, Washington, DC.

Scott-Conerly, Nickens, E., N., Brown, A., Coleman King, & M., Mitchell, P. (2004, January). Proactive strategies to address date rape on college campuses. Workshop presented at the District of Columbia Counselors Association, Washington, DC.

Scott-Conerly, N., Nickens, E., Brown, A., Coleman King, M., Mitchell, P. (2003, November). Innovative Outreach Programs. First Counseling Center Conference for Mental Health Professionals at Historically Black Colleges and Universities, Hunt Valley, MD.

Fullilove, M., Hernandez-Cordero, L., Mitchell, P., Kaufman, M. (2003, February). Mental Illness In the City: An Ethnographic Study of People Seeking Care. Paper presented to PEER Support Program Directors at Columbia Presbyterian Hospital, New York City, NY.

Lopez, F. G., Mitchell, P., & Gormley, B. (2001, August). Adult attachment orientation and distress: Test of a mediational model. Paper presented at the annual meeting of the American Psychological Association, San Francisco, CA.

Mitchell, P. (2001, April). Acculturation and racial identity: The impact of within group variability on therapeutic choice. Paper presented at the Great Lakes Regional Conference for Counseling Psychology, University of Akron, Akron, OH.

Hood, C., Howard, A., & Mitchell, P. (2000, April). Psychotherapy in cyberspace: Ethical implications. Paper presented at the Great Lakes Regional Conference for Counseling Psychology, Ball State University, Muncie, IN.

PROFESSIONAL DEVELOPMENT

Authority, Leadership, Power & Resources: Perspectives on Diversity. June 25 – 27, 2004. Howard University College of Dentistry. Washington, DC. Co-Sponsored by The Washington-Baltimore Center, an Affiliate of the A. K. Rice Institute for the Study of Social Systems and The Howard University Counseling Service.

11th National Conference on Children and the Law: Lawyers and Psychologists Working Together. Sponsored by the American Psychological Association and the American Bar Association Center for Children and the Law. June 3 – 5. Hyatt Regency Washington Hotel, Washington DC

The Eighth Annual Conference on the Contemporary Applications of Psychological Testing. John E. Exner, Jr., PhD, ABPP. April 1 – 3. Boston, MA.

Ethical Decision-Making and the New APA Ethics Code. Howard University, March 30, 2004. Stephen Behnke, J.D., Ph.D., Director, APA Ethics Office.

Wechsler Intelligence Scale for Children – Fourth Edition Training. October 31, 2003. Sponsored by the Counseling Psychology Student Association. Howard University School of Education. Washington DC

Suicidal Illness: Treating Your Suicidal Patients. Sponsored by the Howard University College of Medicine: Department of Psychiatry and the National Organization for People of Color Against Suicide, Inc. October 27, 2003 Howard University. Washington DC

A Residential Group Relations Conference in the Tavistock Tradition Sponsored by the Washington-Baltimore Center, an affiliate of the A.K. Rice Institute for the Study of Social Systems. August, 2003. Bryn Mawr College, Bryn Mawr, PA

SUPERVISION

- Counseling Psychology Supervision graduate course (Fall, 2001)
- Supervised Masters level counseling psychology student (individual)
- Supervised by Linda Forrest, Ph.D. and Gloria Smith, Ed.D.

SERVICE

- **Howard University Counseling Service** - conduct outreach activities to educate the Howard University community in preventive mental health strategies, presenting workshops on stress, adjustment to the University, career choice, etc. Participate in primary prevention activities with other mental health centers across the US during National Depression Screening Day and National Alcohol Screening Day. Crisis intervention to help victims resume their lives
  (August, 2003 – Present)
- **Columbia University Mailman School of Public Health's Community Research Group** – *"take heart"* workshop co leader providing various agencies and business leaders around New York City with motivational and wellness activities and the tools to begin thinking about their own missions and activities to be implemented within their own organizations and communities designed to continue to help New York City recover from September 11
  (June, 2003)

- **Michigan State University Counseling Psychology Program Interview Day** – assisted in the applicant interview process/evaluation
  (February, 2001)

- **Michigan State University Counseling Psychology Program Interview Day** – assisted in the applicant interview process/evaluation. Developed and implemented a diversity meeting for applicants of color and those of diverse sexual orientations and present students of color and diverse sexual orientations geared toward providing a safe space for applicants to converse and ask questions of present students regarding their experiences
  (February, 2000)

- **#NYNE Crisis Line** – provided crisis assistance to university students and the Norman, Oklahoma community in developing choices in resolving crisis and provided direction to resources; made routine referrals and maintained contact with area counselors, social workers, and other social service providers
  (September, 1996 – January, 1997)

- **Juvenile Services of Norman** – employed play therapy techniques with battered and sexually abused children under the supervision of specialized therapists
  (August, 1995 – December, 1995)

REFERENCES

REFERENCES

Acosta, G. (1980). Self-described reasons for premature termination of psychotherapy of Mexican Americans, Black American, and Anglo American patients. *Psychological Reports, 47*, 435 – 443.

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the context of help seeking. *American Psychologist, 58,* 5 – 14.

Ary, D., Jacobs, L. C., & Razavieh, A. (1996). *Introduction to research in education* (5th ed.). Fort Worth, TX: Harcourt Brace College Publishers.

Atkinson, D. R., Thompson, C. E., & Grant, S. K. (1993). A three-dimensional model for counseling racial/ethnic minorities. *The Counseling Psychologist, 21,* 257 – 277.

Barbee, E. L. (1992). African American women and depression: A review and critique of the literature. *Archives of Psychiatric Nursing, 6,* 257 – 265.

Bogden, R., & Biklen, S. K. (1998). *Qualitative research for education: An introduction to theory and methods.* Boston, MA. Allyn and Bacon.

Boyd-Franklin, N. (1987). Group therapy for Black women: A therapeutic support model. *American Journal of Orthopsychiatry, 57,* 394 – 401.

Boyd-Franklin, N. (1991). Recurrent themes in the treatment of African American Women in group psychotherapy. *Women & Therapy, 11,* 25-40.

Brown, D. R. (2003). A conceptual model of mental health and well-being for African American women. In D. R. Brown & V. B. Keith (Eds.), *In and out of our right minds: The mental health of African American women* (pp. 1 – 19). New York, NY: Columbia University Press.

Brown, K. A., Parker-Dominguez, T., & Sorey, M. (2000). *Life stress, social support, and well-being among college-educated African American women. Journal of Ethnic & Cultural Diversity in Social Work, 9,* 55 – 73.

Brown, C., Abe-Kim, J. S., & Barrio, C. (2003). Depression in ethnically diverse women: Implications for treatment in primary care settings. *Professional Psychology: Research and Practice, 34,* 10 – 19.

Caldwell, C. H. (1996). Predisposing, enabling, and need factors related to patterns of help-seeking among African American women. In H. W. Neighbors & J. S. Jackson (Eds.), *Mental health in Black America* (pp. 146 – 160). Thousand Oaks, CA: Sage Publications.

Caldwell, C. H. (2003). Patterns of mental health services utilization among Black women. In D. R. Brown & V. B. Keith (Eds.), *In and out of our right minds: The mental health of African American women* (pp. 258 – 274). New York, NY: Columbia University Press.

Carrington, C. H. (1980). Depression in Black women: A theoretical appraisal. In L. Rogers-Rose (Ed.), *The Black woman* (pp. 265 – 271). Beverly Hills, CA: Sage.

Chisholm, J. F. (1996). Mental health issues in African-American women. In J. A. Sechzer, S. M. Pfafflin (Eds.), *Women and Mental Health* (pp. 161 –179). New York, NY: New York Academy of Sciences.

Cialdini, R. B., & Trost, M. R. (1999). Social influence: Social norms, conformity, and compliance. In D. Gilbert, S. Fiske, & G. Lindzy (Eds.), *The handbook of social psychology* (Vol. 2, pp. 151–192). Boston: McGraw-Hill.

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment (2nd ed.).* New York, NY: Routledge.

Comas-Diaz, L., (1992). The future of psychotherapy with ethnic minorities. *Psychotherapy: Theory, Research, Practice, Training* Special Issue: The future of psychotherapy. 29, 88 – 94.

Comas-Diaz, L., & Greene, B. (1994). Overview: Gender and ethnicity in the healing process. In L. Comas-Diaz & B. Greene (Eds.), *Women of color: Integrating ethnic and gender identities in psychotherapy* (pp. 185-193). New York: The Guilford Press.

Corbett, C. C. (1998). Religious coping styles, perceived stress, depression, and professional psychological help-seeking attitudes among African American women. *Dissertation Abstracts International*, 59 (10), 3743. (UMI No. 9910999).

Coyne, J. C., Schwenk, T. L., & Fechner-Bates, S. (1995). Nondetection of depression by primary care physicians reconsidered. *General Hospital Psychiatry, 17*, 3 – 12.

Dana, R. H. (2002). Mental health services for African Americans: A cultural/racial perspective. *Culutral Diversity and Ethnic Minority Psychology, 8,* 3 – 18.

Denzin, N. K., & Lincoln, Y. S. (1994). Introduction: Entering the field of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1 – 22). Thousand Oaks: CA. Sage Publications.

DuBois, W. E. B. (1969). *Darkwater: Voices from within the veil.* New York, NY: AMS Press.

Edmonson Bell, E. L. J., & Nkomo, S. M. (1998). Armoring: Learning to withstand racial oppression. *Journal of Comparative Family Studies, 29,* 285 – 295.

Eisenhart, M. A., & Howe, K. R. (1992). Validity in educational research. In M. D. LeCompte, W. L. Millroy, & J. Preissle, (Eds.), *The handbook of qualitative research in education* (pp. 643 – 680). San Diego, CA: Academic Press, Inc.

Espin, O. M. (1993). Feminist therapy: Not for or by the White women only. *The Counseling Psychologist, 21,* 103 – 108.

Flaskerud, J. H. (1991). Effects of an Asian client-therapist language, ethnicity, and gender match on utilization and outcome of therapy. *Community Mental Health Journal, 22,* 127 – 141.

Flaskerud, J. H., & Hu, L. (1992). Racial/ethnic identity and amount and type of psychiatric treatment. *American Journal of Psychiatry, 149,* 379 – 384.

Frame, M. W., Williams, C. B., & Green, E. L. (1999). Balm in Gilead: Spiritual dimensions in counseling African American women. *Journal of Multicultural Counseling and Development, 27,* 182 – 192.

Gallo, J. J., Marino, S., Ford, D., & Anthony, J. C. (1995). Filters on the pathway to mental health care, II. Sociodemographic factors. *Psychological Medicine, 25,* 1149 - 1160.

Geronimus, A. T. (1992). The weathering hypothesis and the health of African-American women and infants: Evidence and speculations. *Ethnicity and Disease, 2,* 207 – 221.

Gibbs, J. T., & Fuery, D. (1994). Mental health and well-being of Black women: Toward strategies of empowerment. *American Journal of Community Psychology, 22,* 559 – 582.

Glasser, & Strauss (1967). *The discovery of grounded theory.* Chicago, IL: Aldine.

Gray, B. A., & Keith, V. M. (2003). The benefits and costs of social support for African American women. In D. R. Brown and V. M. Keith (Eds.), *In and out of our right minds: The mental health of African American women* (pp. 242 – 257. New York, NY: Columbia University Press.

Greene, B. (1994). African American women. In L. Comas-Dias & B. Greene (Eds.), *Women of color: Integrating ethnic and gender identities in psychotherapy* (pp. 10 – 29). New York: Guilford.

Greene, B. (1996). African American women: Considering diverse identities and societal barriers in psychotherapy. In J. A. Sechzer, S. M. Pfafflin, F. L. Denmark, A. Griffin, & S. Blumenthal (Eds.), *Women and mental health* (pp. 191 - 209). New York: New York Academy of Sciences.

Helms, J. (1984). Toward a theoretical explanation of the effects of race on counseling: A Black and White model. *The Counseling Psychologist, 12,* 153 – 164.

Hughes, L. (1926). Mother to son. In A. Bontemps, *American Negro poetry*, (pp. 67). New York, NY: Hill and Wang.

Jackson, A. P., & Sears, S. J. (1992). Implications of an Afrocentric worldview in reducing stress for African American women. *Journal of Counseling and Development, 71,* 184 – 190.

June, L. N. (1986). Enhancing the delivery of mental health and counseling services to Black males: Critical agency and provider responsibilities. Journal of *Multicultural Counseling and Development, 14,* 39 – 45.

Kessler, R. C. (1979). Stress, social status, and psychological distress. *Journal of Health and Social Behavior, 20,* 259 – 279.

Kessler, R. C., McGonagle, K. A., Zhao, S., Neson, C. B., Hughes, M., Eshleman, S. et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry, 51,* 8 – 19.

Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional openness as a predictor of college student's attitudes toward seeking psychological help. *Journal of Counseling Psychology, 47,* 138 – 143.

Landrine, H., & Klonoff, E. A. (1995). The African American acculturation scale II: Cross-validation and short form. *Journal of Black Psychology, 21,* 124 – 152.

Landrine, H., & Klonoff, E. A. (1996). *African American acculturation: Deconstructing race and reviving culture.* Thousand Oaks, CA: Sage Publications.

LeCompte, M.D., & Preissle, J., with Tesch, R. (1993). Ethnography and qualitative design in educational research (2nd ed.). New York, NY: Academic Press.

Lincoln, E. (1974). *Forward.* In L. E. Barratt (Ed.), Soul force, (pp. viii). New York, NY: Anchor Press/Doubleday.

Lincoln, K. D., & Chatters, L. M. (2003). Keeping the faith: Religion, stress, and psychological well-being among African American women. In D. R. Brown & V. M. Keith (Eds.), *In and out of our right minds: The mental health of African American women* (pp. 223 - 241). New York, NY: The Columbia University Press.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Link, B., & Dohrenwend, B. P. (1980). Formulation of hypotheses about the true prevalence of demorilization in the United States. In B. P. Dohrenwend (Ed.), *Mental illness in the United States: Epidemiologic estimates* (pp. 114 – 130). New York: Praeger.

Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health, 89,* 1328 – 1333.

Lott, B., & Bullock, H. E. (2001). Who are the poor? *Journal of Social Issues, 57,* 189 – 206.

Marshall, C., & Rossman, G. B. (1999). *Designing qualitative research* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Matthews, A. K., & Hughes, T. L. (2001). Mental health service use by African American women: Exploration of subpopulation differences. *Cultural Diversity and Ethnic Minority Psychology, 7,* 75 – 87.

Mays, V. M. (1995). Black women, work stress, and perceived discrimination: The focused support group model as an intervention for stress reduction. *Culturally Diverse Mental Health, 1, 53* – 65.

Mays, V. M., Caldwell, C. H., & Jackson, J. S. (1996). Mental health symptoms and service utilization patterns of help-seeking among African American women. In H. W. Neighbors & J. S. Jackson (Eds.), *Mental Health in Black America* (pp. 161-176). Thousand Oaks, CA: Sage Publications.

Mays, V. M., & Comas-Diaz, L. (1988). Feminist therapy with ethnic minority populations: A closer look at Blacks and Hispanics. In M. A. Dutton-Douglas and L. E. A. Walker (Eds.), *Feminist psychotherapies: Integration of therapeutic and feminist systems*, (pp. 228-251). Westport, CT: Ablex Publishing.

Merriam, S. B. (1988). *Case study research in education: A qualitative approach.* San Francisco, CA: Jossey-Bass.

Merriam, S. B. (1998). *Qualitative research and case study approaches in education.* San Francisco, CA: Jossey-Bass Publishers.

Morris, E. F. (2001). Clinical practices with African Americans: Juxtaposition of standard clinical practices and Africentrism. *Professional Psychology: Research and Practice, 32,* 563 – 572.

Musgrave, C. F., Allen, C. E., & Allen, G. J. (2002). Spirituality and health for women of color. *American Journal of Public Health, 92, 557* – 560.

Myers, L. W. (1980). *Black women: Do they cope better?* Englewood Cliffs, NJ: Prentice-Hall.

Neal, A. M., & Turner, S. M. (1991). Anxiety disorders research with African Americans: Current status. *Psychological Bulletin, 109,* 400 – 410.

Neighbors, H. W. (1984). Professional help use among Black Americans: Implications for unmet needs. American *Journal of Community Psychology, 12,* 551 – 566.

Neighbors, H. W. (1985). Seeking professional help for personal problems: Black Americans' use of health and mental health services. *Community Mental Health Journal, 21,* 156 – 166.

Neighbors, H. W. (1997). Husbands, wives, family, and friends: Sources of stress, sources of support. In R. J. Taylor, J. S. Jackson, and L. M. Chatters, (Eds.), *Family life in Black America,* 279 – 293. Thousand Oaks, CA: Sage.

Neighbors, H. W., Caldwell, C. H., Thompson, E., & Jackson, J. S. (1994). Help-seeking behavior and unmet need. In S. Friedman (Ed.), *Anxiety disorders in African Americans* (pp. 26 – 39). New York, NY: Springer Publishing Company.

Neighbors, H. W., & Jackson, J. S. (1984). The use of informal and formal help: Four patterns of illness behavior in the Black community. *American Journal of Community Psychology, 12,* 629 – 644.

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 and Behavior. Special Issue. Public Health and Health Education in Faith Communities, 25, 759 – 777.

Nickerson, K. J., Helms, J. E., & Terrell, F. (1994). Cultural mistrust, opinions about mental illness, and Black student's attitudes toward seeking psychological help from White counselors. *Journal of Counseling Psychology, 41,* 178 – 385.

O'Dea, T. F. (1966). *The sociology of religion.* Englewood Cliffs, NJ: Prentice Hall.

O'Hare, W., Pollard, K. M., Mann, T. L., & Kent, M. M. (1991). African Americans in the 1990's. *Population Bulletin, 46,* 1 – 40.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy: Noch einmal. In A. E. and S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change (4th ed.) (pp. 270 – 376). Oxford, England: John Wiley & Sons.

Padgett, D. K., Patrick, C., Burns, B. J., & Schlesinger, H. J. (1994). Women and outpatient mental health services: Use by Black, Hispanic, and White women in a national insured population. *Journal of Mental Health Administration, 21,* 347 – 360.

Pearlin, L. I., Lieberman, M. A., Menaghan, E. G., & Mullan, J. T. (1981). The stress process. *Journal of Health Social Behavior, 22,* 337 – 356.

Qualitative psychological research (February 16 2004). http://en.wikipedia.org/wiki/Qualitative_psychological_research.

Richardson, B. L., & June, L. N. (1997). Utilizing and maximizing the resources of the African American church: Strategies and tools for counseling professionals. In C. C. Lee (Ed.), *Multicultural issues in counseling: New approaches to diversity* (pp. 155 – 170). Alexandria, VA: American Counseling Association.

Robins, L. N., Helzer, J. E., Croughan, J., & Ratcliff, K. (1981). National institute of mental health diagnostic interview scheduled: Its history, characteristics, and validity. *Archives of General Psychiatry, 38,* 381 – 389.

Romero, R. E. (2000). The icon of the strong Black woman. In L. C. Jackson & B. Greene (Eds.), *Psychotherapy With African American Women: Innovations in psychodynamic perspectives and practice* (pp. 225 – 238). New York, NY: Guilford Press.

Schulz, A., Israel, B., Williams, D., Parker, E., Becker, A., & James, J. (2000). Social inequalities, stressors and self reported health status among African American and white women in the Detroit metropolitan area. *Social Science & Medicine, 51,* 1639 – 1653.

Shorter-Gooden, K., & Washington, N. C. (1996). Young, Black, and female: The challenge of weaving an identity. *Journal of Adolescence, 19,* 465 – 475.

Smith, E. J. (1981). Mental health and service delivery systems for Black women. *Journal of Black Studies, 12,* 126-141.

Smith, E. J. (1985). Counseling Black women. In P. Pedersen (Ed.), *Handbook of cross cultural counseling and therapy* (pp. 181-187). New York: Praeger.

Snowden, L. R. (1999). African American service use for mental health problems. *Journal of Community Psychology, 27,* 303 – 313.

Snowden, L. R., & Hines, A. M. (1999). A scale to assess African American acculturation. *Journal of Black Psychology, 52,* 36 – 47.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage Publications.

Sue, S. (1977). Community mental health services to minority groups. *American Psychologist, 32,* 616-624.

Sue, S., Fujino, D. C., Hu, L., Takeuchi, D. T., & Zane, N. W. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 42,* 794 – 801.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different (2nd ed.).* New York: Wiley.

Sussman, L. K., Robins, L. N., & Earl, F. (1987). Treatment-seeking for depression by Black and White Americans. 187 – 196.

Suzuki, L. A., Prendes-Lintel, M., Wertlieb, L., & Stallings, A. (1999). Exploring multicultural issues using qualitative methods. In M. Kopala & Suzuki, L. (Eds.), *Using Qualitative Methods in Psychology* (pp. 123 – 133). Thousand Oaks, CA: Sage Publications.

Taylor, M. J. (1999). Changing what has gone before: The enhancement of an inadequate psychology through the use of an Afrocentric-feminist perspective with African American women in therapy. *Psychotherapy: Theory, Research, Practice, Training, 36,* 170 – 179.

Taylor, R. J., Ellison, C. G., Chatters, L. M., Levin, J. S., & Lincoln, K. D. (2000). Mental health services in faith communities: The role of clergy in Black churches. *Social Work, 45,* 73 – 87.

Taylor, J., Henderson, D., & Jackson, B. B. (1991). A holistic model for understanding and predicting depressive symptoms in African American women. *Journal of Community Psychology, 19,* 306 – 320.

Terrell, F., & Terrell, S. (1984). Race of counselor, client sex, cultural mistrust level, and premature termination from counseling among Black clients. *Journal of Counseling Psychology, 31,* 371-375.

Thompson, C. E., Worthington, R., & Atkinson, D. R. (1994). Counselor content orientation, counselor race, and Black women's cultural mistrust and self-disclosures. *Journal of Counseling Psychology, 41,* 155 – 161.

Timlin-Scalera, R. M., Ponterotto, J. G., Blumberg, F. C., & Jackson, M. A. (2003). A grounded theory study of help-seeking behaviors among White male high school students. *Journal of Counseling Psychology, 50,* 339 – 350.

Vega, W. A., & Rumbaut, R. G. (1991). Ethnic minorities and mental health. *Annual Review of Sociology, 17,* 151 – 383.

Vogel, D. L., & Wester, S. R. (2003). To seek help or not to seek help: The risks of self-disclosure. *Journal of Counseling Psychology, 50*, 351 – 361.

Wallen, J. (1992). Providing culturally appropriate mental health services for minorities. *Journal of Mental Health Administration* Special Issue: Multicultural mental health and substance abuse services, 19, 288 – 295.

Warren, B. J. (1997). Depression, stressful life events, social support, and self-esteem in middle class African American women. *Archives in Psychiatric Nursing, 11,* 107 – 117.

Watkins, C. E., Terrell, F., Miller, F., & Terrell, S. (1989). Cultural mistrust and its effects on expectational variables in Black client-White counselor relationships. *Journal of Counseling Psychology, 36,* 447 – 450.

Weiss, R. S. (1994). *Learning from strangers: The art and method of qualitative interview studies.* New York, NY: Free Press.

West, J. S., Kayser, L., & Overton, P., & Saltmarsh, R. (1991). *Student perceptions that inhibit the initiation of counseling. School Counselor, 39,* 77 - 83.

Whaley, A. I. (1998). Cross-cultural perspective on paranoia: A focus on the Black American experience. *Psychiatric Quarterly, 69,* 325 – 343.

Williams, C. B. (1999). African American women, afrocentrism and feminism: Implications for therapy. *Women and Therapy, 22,* 1 – 16.

Williams, C. B., Frame, M. W., & Green, E. (1999). Counseling groups for African American women: A focus on spirituality. *Journal of Specialists in Group Work, 24,* 260 – 273.

Williams, D. R., & Harris-Reid, M. (1999). Race and mental health: Emerging patterns and promising approaches. In A. V. Horowitz & T. L. Scheid (Eds.), *A handbook for the study of mental health: Social contexts, theories, and systems* (pp. 295 – 314). New York, NY: Cambridge University Press.

Williams, D. R. (2000). Race, stress, and mental health. In C. J. Hogue, M. A. Hargraves, & K. S. Collins (Eds.), *Minority health in America: Findings and policy implications from the Commonwealth Fund Minority Health Survey* (pp. 209 – 243). Baltimore, MD: Johns Hopkins University Press.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method.* Philadelphia, PA: Open University Press.

Ziedonis, D. M., Rayford, B. S., Bryant, K. J., & Rounsaville, B. J. (1994). Psychiatric comorbidity in white and African-American cocaine addicts seeking substance abuse treatment. *Hospital and Community Psychiatry, 45,* 43 – 49.