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Stigma, race and mental illness : African-American clinicians' perceptions of how these factors influence help-seeking behaviors in African Americans

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ABSTRACT

This qualitative study explored the stigma of mental illness within the African American community from the perspective of African American clinicians. Nine clinicians were interviewed and were asked to discuss personal messages received about mental illness within their family, community, and religious organizations. They also shared their perceptions of African American attitudes, based upon client interactions, towards mental illness and whether a change has occurred within the past 5-10 years; identifiable stigmas within the African American community; inhibitors to help-seeking behaviors; variables that influences help-seeking behaviors; and their recommendations for improving African Americans' comfort with disclosure within the therapeutic setting.

The findings from the study revealed that negative stigma about mental illness remains dominant within the African American community and that many of its members also hold negative attitudes about mental illness. However, the findings did also show that a slight positive shift in stigma and attitudes has occurred. Additional findings addressed the key role that family plays in messages received about mental illness, the association between mental illness and religion/spirituality for many African Americans, and the importance of establishing rapport as being central to the therapeutic relationship in improving African Americans' comfort with disclosure within the therapeutic setting.

Future research should focus on the further development of recommendations to decrease the negative attitudes and stigmas regarding mental illness within the African American community, as well as further exploring the role of the African American family as it relates to mental illness symptom identification and seeking mental health services.

STIGMA, RACE AND MENTAL ILLNESS: AFRICAN AMERICAN CLINICIANS'

PERCEPTION OF HOW THESE FACTORS INFLUENCE HELP-SEEKING

BEHAVIORS IN AFRICAN AMERICANS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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CHAPTER I

Introduction

Mental illness affects many human beings regardless of their race, ethnicity, pedophilic gender, religion, and socio-economic status, etc. Stigma associated with mental illness prevents many people from seeking diagnosis and treatment. This is especially true for African Americans and the African American community, as illustrated by an observation during this researcher's first year internship. I worked in a setting where individual counseling services were provided to women residing in a six-month halfway house that served up to 10 alcohol/drug addicted women, and those who were dually diagnosed. The majority of the women counseled within the halfway house self-identified as African-American (usually an 8:2 ratio) and had a primary substance abuse/alcohol related diagnosis. As counseling sessions with these women progressed, there was a distinct reluctance and hesitation to talk about their mental health needs. When their reluctance was addressed directly, the common explanations for their hesitation/resistance in engaging in mental health dialogue was either, "I am not 'crazy,'" that "God will pull me through," or that "… [mental illness] is a [White people] thing." These responses indeed validate a qualitative study conducted by Sanders-Thompson, Bazile, and Akbar using focus groups with African-Americans revealing "stigmatizing attitudes about people with mental illness…" (as cited in Anglin, Link, & Phelan, 2006, p. 857).

This researcher's internship experiences, coupled with research findings on attitudes about mental illness, are examples that provide insight into how mental illness is viewed by some

members within the African-American community; and how such attitudes may influence community members when mental health services are needed.

This researcher hypothesizes that by exploring the stigma of mental illness within the African American community, those barriers and challenges that serve as prohibitory to seeking mental health services within the African American community will surface, both individually and collectively. Furthermore, external challenges (e.g., inaccessible mental health service locations) that some African Americans face in seeking services as well as some of the internal challenges (e.g., shame) that African Americans face once in treatment will be identified. These findings are especially important for clinicians who work with African Americans because African Americans are more likely to experience a mental disorder than their White counterparts, but "less likely to seek treatment," ("Eliminate Heath Disparities Fact Sheet" (http://www.cdc.gov/omhd/amh/factsheets/mental.htm). Findings from this study will provide relevance for social work practice in thinking about how to engage African American clients and how to eliminate some of their fears about mental health treatment. Findings are most impactful for those clinicians or individuals in the mental health field working in more urban and high-poverty areas, which tend to be further populated with people of color (e.g., African-Americans).

Mental health and mental illness as defined for this study captures the U.S. Surgeon General's Report. According to a 1999 Mental Health Report of the U.S. Surgeon General as cited in Goldman and Grob (2006):

> Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and an ability to adapt to change and to cope with adversity…Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are

characterized by alterations in thinking, mood, or behavior (or some combination thereof)

associated with distress and/or impaired functioning. (p. 738)

While both terms 'mental health and mental illness' are used collectively and sometimes

interchangeably, the definition provided for "mental illness" remains dominant throughout this

research. Stigma in this study is defined as "a collection of negative attitudes, beliefs, thoughts,

and behaviors that influences the individual, or the general public, to fear, reject, avoid, be

prejudiced, and discriminate against…"(Gary, 2005, p. 980).

This research study reports the truthfulness and generalizability of the belief that there is

a great stigma surrounding mental illness within the African American community. Furthermore,

this study reports this belief through the perspective of African American clinicians. African

American clinicians were chosen for this study largely due to the fact that there have not been

many research studies conducted using this population. In addition, using clinicians as the

research participants provides a different lens for looking at the issue of mental illness within the

African American community; the lens of those actually providing mental health services, rather

than receiving services.

There are some limitations to this study. This study was conducted using a relatively

small sample size (9 clinicians) and therefore, may not represent the perceptions of all African

American clinicians. Also, the demographic distribution within the sample size could lead to

some distortion of results as the diversity is limited in gender and clinical setting. The findings

are intended to show how African American clinicians perceive the stigma of mental illness

within the African American community, and how such stigma can be addressed to provide

greater support and understanding of African Americans who seek mental health services. In

order to better educate African Americans on the benefits of mental illness support, it is

important for clinicians, whether they are social workers, psychologists, mental health professionals or counselors, to understand and be aware of the unique characteristics of the African American community, and its members.

Summary

African Americans are a distinct population with a long history of stigma marked by negative attitudes, beliefs, thoughts, and behaviors emanating from prejudice, discrimination and stereotypic attitudes that impact their help-seeking behaviors when mental health services are needed. While research has shown that African Americans are at greater risk to experience psychological issues than their White counterparts, it also has shown that African Americans are less likely to seek out professional help. The purpose of this study was to explore the stigma of mental illness within the African American community from the perspective of African American clinicians. More specifically, this study sought to examine African American clinicians' perceptions of whether the stigma of mental illness within the African American community hinder its members from seeking mental health services, and if those stigmas then affect the therapeutic setting.

CHAPTER II

Literature Review

This chapter provides a review of literature on the perception of mental illness and mental health treatment within the African American community, and internal and external factors that impact their help-seeking behaviors. More specifically this literature examines: 1) messages and attitudes regarding mental illness and treatment; 2) stigma and mental illness; 3) theories that can help in the exploration of the internalized views that African Americans have in seeking services (Racial Identity Theory) as well as how stigma (perceived or not) frames an individual's resistance in approaching certain situations, such as seeking mental health services (Stigma Theory); 4) internal and external barriers that hinder/prevent African Americans from seeking mental health services; and 5) strategies for improving attitudes, help-seeking behaviors, and the therapeutic relationship with African American clients. The strengths and weaknesses of the literature also are discussed, as well as the implications this literature review has upon the current study.

Messages and Attitudes Regarding Mental Illness and Treatment

Research on African American communities show the existence of numerous messages that its members hold about mental illness. Some of these messages include the belief that individuals with mental illness and mental illness itself are to be feared, that individuals with mental illness are "crazy", that mental illness is permanent, and that mental illness is all consuming and can take over one's way of being (Hines-Martin, Malone, Kim, & Brown-Piper, 2003; Matthews, Corrigan, Smith & Aranda, 2006; Mishra, Lucksted, Gioia, Barnet & Baquet,

2009; Roberts et al., 2008; Ward & Heidrich, 2009). In some research, mental illness is seen through two separate lenses, good mental health and poor mental health (Matthews et al., 2006 and Roberts et al., 2008). Some of the descriptors and statements used to define good mental health include, "stable/a stable mind", "having a positive attitude", "they [the mentally ill] are able to cope", "happy", and "they have inner peace" (Matthews et al., 2006 and Roberts et al., 2008). Descriptors and statements used to define poor mental health include "withdrawn", "stressed", "unable to cope", "disruptive behavior", "they [the mentally ill] are unbalanced", and "not taking care of their personal hygiene" (Matthews et al., 2006 and Roberts et al., 2008). Importantly, those descriptors and statements often used to describe poor mental health mostly are referred to as severe mental illness (Matthews et al., 2006 and Roberts et al., 2008). Mild and moderate mental illness is not recognized; and mental illness is predominantly recognized when severe symptoms are present (Roberts et al., 2008). Somewhat in support, Mathews et al. (2006) also found that participants [African American] using the term severe mental illness were less able to draw a distinction between those suffering from experiences that affected mental health and those actually experiencing a severe mental illness. This coincides with the findings of a 2003 research study where Hines-Martin et al. reported that many of their participants [African-American] identified mental illness as dichotomous states and presented a view of mental illness as being "all or nothing". Illustrations of the "all or nothing" way of thinking also was seen in a study that used focus groups to better understand the mental health/illness information and service delivery preferences among African American residents in Baltimore. Within the study some participants reported the message that "there's no way back from mental illness. If I tell someone that I have a mental illness that's it, I'm finished", while another participant reported a view that "mental illness is more terminal…" (Mishra et al., 2009).

Additional messages about mental illness included reports that it is viewed as something that can be controllable (Ward & Heinrich, 2009); and that mental illness improves overtime on its own (Anglin, Alberti, Link & Phelan, 2008). Furthermore, family-related stress, which include trauma, family problems, violence, and social stress were messages received about the possible causes of mental illness (Ward & Heidrich, 2009).

In terms of attitudes regarding mental illness, some research shows that members of the African American community tend to have a negative attitude/response to mental illness (Connor, Koeske & Brown, 2009; Matthews et al., 2006; Sanders-Thompson, Bazile & Akbar, 2004). For example, Connor et al. (2009) found that "African American participants endorsed significantly more negative attitudes toward mental health services than Whites" (p. 706). However, other studies noted gender and educational background as variables that create a difference in the negative attitudes regarding mental illness held by some African Americans. In Ward and Heidrich (2009), it was suggested that African-Americans with higher levels of education tended to have less negative attitudes towards mental health in comparison to African-Americans with lower levels of education (Ward & Heidrich, 2009). Wallace and Constantine (2005) reported that African-American women indicated more positive attitudes regarding mental illness than African-American men. While attitudes towards treatment for mental illness tended to be negative in general, (Connor et al., 2009; Matthews et al., 2007; Woodward, Mowbry, Holter & Bybee, 2007) some studies reported that African-Americans held less negative and more hopeful attitudes towards mental health treatment (Anglin et al., 2008; Sanders-Thompson et al, 2004; Wallace & Constantine, 2005; Ward & Heidrich, 2009;). The research also has noted differences in age and gender as factors that affect attitudes towards mental health treatment, reporting older individuals having more positive attitudes compared to

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younger individuals (Ward & Heidrich, 2009); and women having more positive help seeking attitudes than men (Wallace and Constantine, 2005).

Other help seeking behaviors used by African Americans to cope or deal with their mental illness or emotional problems is religion, use of friends network, and self-medication. Research on the use of informal support networks (e.g. friends and family) (Matthews et al., 2006; Mishra et al., 2009; Sanders-Thompson et al., 2004; Ward & Heidrich, 2009), self-medication (i.e. over-eating, using drugs, or drinking) (Matthews et al., and Roberts et al., 2006) and avoidance (Ward & Heidrich, 2009) define these treatment options.

The use of religion and spirituality as a way of coping specifically focused on the use of prayer (Chatters, Taylor, Jackson & Lincoln, 2008 and Sanders-Thompson et al., 2004), the use of the church (including priests, pastors, or clergy) (Blank et al., 2002), and the use of God (Chatters et al., 2008 and Roberts et al., 2006). However, some of the literature simply discussed the general terms of religion and spirituality as ways of coping (Matthews et al., 2006 and Ward & Heidrich, 2009). Chatters et al. (2008) examined demographic predictors of attitudes regarding religious coping (e.g. prayer during stressful times) within a national sample of African Americans (3,570), Caribbean Blacks (621), and non-Hispanic Whites (890). Their findings reported that almost 89.7% of African American reported that they "strongly agree" that they look to God for strength and support and 90.4% of African Americans strongly endorsed the opinion that prayer is important when dealing with stressful situations. Similar findings were found in other literature where it was reported that older (Ward & Heidrich, 2009) as well as more religious participants [African American] (Sanders-Thompson, 2004) reported the use of prayer as a way of coping. However, Sanders-Thompson (2004) further reported that despite this finding, the use of prayer, as a way of coping was not widely endorsed.

Stigma Associated with Mental Illness

Stigma associated with mental illness is a pervasive problem within the African-American community (Matthews et al., 2006 and Roberts et al., 2008). Research suggests stigma to be a notable barrier/factor for African Americans when it comes to seeking mental health treatment/services (Bathje & Pryor, 2011; Connor et al., 2009; Matthews et al., 2006; Mishra et al., 2009; Sanders-Thompson et al., 2004;). Terms used to describe the stigma associated with mental illness have included shame (Matthews at al., 2006; Mishra et al., 2009; Sanders-Thompson et al., 2004), embarrassment (Matthews et al., 2006 and Sanders-Thompson et al, 2004), disgrace (Matthews et al., 2006), dishonor, unpredictable, and contagious (Mishra et al., 2009). In addition, terms used to describe the stigma attached to individuals with mental illness have included violent (Anglin, Link and Phelan, 2006), dangerous (Anglin et al., 2006 and Mishra et al., 2009), crazy (Matthews et al., 2006), and hopeless (Mishra et al., 2009). While the research highlights the terms associated with mental illness stigma, it also addresses the views African Americans hold in terms of the consequences related to mental illness stigma and the detrimental impact mental illness stigma will have/has on individual lives (Matthew et al., 2006 and Mishra et al., 2009). Very similar to some of the terms associated with mental illness stigma (shame and embarrassment), consequences associated with mental illness stigma and the detrimental impact mental illness stigma has/will have include social distance/rejection (Matthews et al., 2006 and Sanders-Thompson et al., 2004), loss of social relationships and "normal" status/social status (Matthews et al., 2006 and Mishra et al., 2009), the appearance of being weak, either personally or spiritually, and labeling (Mishra et al., 2009 and Sanders-Thompson et al, 2004). As a result of the stigma associated with mental illness and those with mental illness, there is a large fear of being "found out" or revealed and an intense need for

anonymity, confidentiality, and reassurance (Mishra et al., 2009). This further helps to better understand stigma acting as a barrier among African Americans in the utilization of mental health treatment/services. Interestingly, in a different study conducted by Ward and Heidrich (2009) that explored African American women's beliefs about mental illness and its treatment, the participants reported that they would not be embarrassed if friends knew they were getting professional help. Furthermore, they reported low levels of stigma associated with seeking mental health treatment/services. However, the researchers suggested that this difference could be associated with educational level of the participants (median educational level was 2 years of college or technical college), higher level of mental health services available in the community, and the history of community based mental health care.

Theories

    Stigma theory. Stigma theory helps to understand how stigma (perceived or not) frames an individual's resistance in approaching certain situations (e.g., seeking mental health services), or interacting with certain individuals because of the potential for discrimination and rejection by others. Within stigma theory, theorists also have defined different forms of stigma, such as public-stigma, self-stigma, and structural stigma and how they all interrelate with each other. Helpful definitions include those for public-stigma and self-stigma, as they often are discussed in the research discussing African American attitudes towards mental illness and mental health treatment. Public stigma, as defined by Corrigan and Watson (2002), refers to "the negative beliefs, attitudes, and conceptions about mental illness held by the general population, which lead to stereotyping, prejudice, and discrimination against individuals with mental health disorders (as cited in Connor et al., 2009, p. 697), while self-stigma as defined by Bathje and Pryor (2011) is "the internalized psychological impact of possessing a stigmatizing

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characteristic". Research also has found that there is a significant relationship between public stigma awareness and self-stigma and that the endorsement of public stigma and self-stigma were directly related to individuals' attitudes about seeking counseling (Bathje & Pryor, 2011). Conner et al. (2009) also reported that public stigma and internalized stigma (self-stigma) were highly and significantly negatively correlated with attitudes toward seeking mental health services. In other words, individuals with a high level of public and internalized stigma also were more likely to have negative attitudes about mental health treatment. Looking specifically at racial differences, Conner et al. also found that African Americans are significantly more likely to have experienced both higher levels of public and internalized stigma than their White counterparts (2009). In addition, age and education was found to be significantly related to both internalized and public stigma (Connor et al., 2009)

Other research on stigma theory has looked at the term "double stigma". The article entitled "Stigma: Barrier to Mental Health Care among Ethnic Minorities," Gary (2005) highlighted 'double stigma' as another aspect of stigma. He referred to double stigma as an individual's membership in two groups and each tend to be stigmatized and discriminated against by the general public. This concept, within stigma theory, may shed light on negative stigma within the African-American community regarding mental health and African Americans' hesitation in seeking out mental health services. In other words, historically many African Americans are stigmatized/discriminated against due to their ethnic membership. Also African Americans with mental illness often are perceived as dangerous and overtly aggressive. Hence there may be a resistance amongst African-Americans in acknowledging their mental health status and/or seeking out mental health services due to their fear of experiencing additional forms

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of discrimination or rejection. This researcher carefully notes, however, that all African-Americans do not feel stigmatized by their racial status.

Racial identity theory. Racial identity, as defined by Helms (1990), refers to the degree to which individuals racially perceive themselves and share a common racial heritage with their racial group (as cited in Townes, Chavis-Korrell, & Cunningham, 2009). In addition, racial identity theory can be mapped out in major phases or stages through which an individual moves in identity development. Understanding and utilizing this theory can be useful in exploring mental health within the African American community, as past research has indicated that racial group membership has important implications for the psychological wellbeing of individuals from minority racial groups (Pyant & Yanico, 2001). Furthermore, utilizing racial identity theory can help in the exploration of the internalized views that African-Americans have in seeking mental health services. For example, Richmond, Kohn-Wood, and Williams (2005) examined the role of race, discrimination and racial identity in explaining mental health service utilization. They found a direct correlation between racial identity and utilization among Black Americans. In support, Woodward et al. (2007), found similar findings in their study that explored potential racial differences in the experiences of support offered by consumer-centered services for adults with serious mental illness. They found that African Americans reported a greater sense of community as the proportion of African American consumers in the program increased.

Looking at racial identity from a different angle, Townes et al. (2009) examined the extent to which Black racial identity attitudes, cultural mistrust, and help-seeking attitudes predicted preference for a Black counselor. Their results revealed that in addition to other factors, racial identity significantly predicted preference for a Black counselor. This finding

helps to understand why many African-Americans may resist seeking mental health services, especially in the White-dominated health field, and also may explain their behavior once the counseling sessions begin. The limitation in this theory however is that everyone's racial identity development differs, therefore reducing the ability to generalize findings to everyone.

Barriers

    Internal. The literature has cited several internal barriers in helping to develop a better understanding of the underutilization of mental health services/seeking of treatment by African Americans. These barriers include trust issues (Hines-Martin et al., 2003; Matthews et al., 2006; Mishra et al., 2009; Sanders-Thompson et al., 2004), personal fears (Mishra et al., 2009 and Sanders-Thompson et al., 2004), lack of knowledge and awareness (Davis, Ressler, Schwartz, Stephens, & Bradley, 2008; Hines-Martin et al., 2003; Matthews et al., 2006; Roberts et al., 2008; Sander-Thompson et al., 2004) and cultural beliefs, (Hines-Martin et al., 2003; Matthews et al., 2006; Mishra et al., 2009; Sanders-Thompson et al., 2004). Additional individual barriers reported included individual physical health and high levels of daily crisis/no time available (Davis et al., 2008), as well as having a sense of control of one's life and one's maintenance of their role in daily life (Hines-Martin et al., 2003).

    The issue of trust largely focuses on a lack of trust surrounding mental health providers (Matthews et al., 2006 and Mishra et al., 2009), efficacy of mental health providers to assist African Americans with their problems (Matthews et al., 2006 and Sanders-Thompson et al., 2004), and the mistrust of others' concerns (Hines-Martin et al., 2003). Statements regarding the issue of trust have included, "Even though a person seeks help, you're not too confident in the help that is given" (Matthews et al., 2006, p. 261) or "I go back to trust again because the Tuskegee experiment was suppose to make these brothers feel real good…you see what

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happened to them" (Mishra et al., 2009, p. 123), or "…You are not going to sit and talk to somebody if you don't trust them…" (Sanders-Thompson et al., 2004, p. 23). Furthermore for African-Americans, race and racism is largely related to the issues of trust surrounding seeking mental health services (Matthews et al., 2006; Mishra et al., 2009; and Sanders-Thompson et al., 2004). There is the perception of ongoing racism within medical establishments (Matthews et al., 2006 and Mishra et al., 2009), concern regarding cultural sensitivity (Sanders-Thompson et al., 2004) and recognition of historical incidences of racism, such as the Tuskegee Syphilis Study (Mishra et al., 2009). Interestingly, in Sanders et al. (2004) study that looked at the attitudes and beliefs of African Americans regarding psychotherapists, psychotherapy, and barriers to treatment, they found that although many participants reported that race should not matter, they discussed their concern that ultimately race does matter.

In terms of personal fears, there are the fears related to being revealed, the loss of "normal" status and social relationships (Mishra et al., 2009) and being misdiagnosed, labeled, and brainwashed (Sanders-Thompson et al., 2004). Somewhat along the same lines, in a 2002 study by Snowden and Pingitore, not only did their data reveal no difference between African Americans and Whites in provisions regarding diagnosis frequency and follow-up appointment request frequency; but also that when expressing a mental health-related complaint, African Americans were less likely than Whites to have a primary care physician deliver psychotropic medications.

Lack of knowledge/awareness is another barrier largely felt within the African American community. There is the perception of lack of awareness about the availability and location of mental health service facilities in and out of the community (Matthews et al., 2006), lack of knowledge about how to obtain services (Davis et al., 2003 and Roberts et al., 2008), lack of

awareness that the problems they are experiencing were "mental health problems, such as signs and symptoms (Hines-Martin et al., 2003; Matthews et al., 2006, Roberts et al., 2008; Sander-Thompson et al., 2004), and difficulty in discerning when a situation or condition reaches a stage requiring professional services (Sanders-Thompson et al., 2004). Statements that have been made regarding the lack of awareness/knowledge included "people don't know about any of the different organizations around here that are willing to help them. They don't know what resources to go to get help" (Sanders-Thompson et al., 2004, p. 22), and "the average person on the street would not recognize the symptoms of depression. And if they did they would ignore it" (Matthews et al., 2006, p. 262).

Cultural beliefs prominent within the African American community that serve as barriers include fear of family and community disapproval (Davis et al., 2008), the need to present a proud and unblemished public face (Mishra et al., 2009), the need to keep information and resolve family concerns within the family or "in house" (Matthews et al., 2006; Mishra et al., 2009; Sanders-Thompson et al., 2004), perception that seeking treatment is a sign of weakness and diminished pride (Sanders-Thompson et al., 2004), and the need to be strong and self-sufficient/self-reliant (Hines-Martin et al., 2003; Matthews et al., 2006; Mishra et al., 2009). It is important to note however that some of the cultural barriers noted differ in variables such as age and gender. For instance in Sanders-Thompson et al. 2004 study that examined the beliefs, attitudes, and expectations of the African American usurps community regarding mental health service providers and use of mental health services in a sample of 201 individuals, they found that most males reported diminished pride and weakness in seeking mental health services, which usurps the importance of being strong black men. Furthermore, they found that older

participants and men were more likely to endorse the continued belief of the need to keep information within the family.

     External. Studies have also revealed that African Americans encounter a multitude of external barriers/obstacles that impede access to mental health services. These barriers relate to financial, environmental and institutional realities (Hines-Martin et al., 2003; Davis et al., 2008; Roberts et al., 2008; Sanders-Thompson et al., 2004). Financial barriers relate to but are not limited to minimal monetary resources (Davis et al., 2008; Matthews et al., 2006; Mishra et al., 2009; Sanders-Thompson et al., 2004), no insurance or lack of adequate insurance to cover mental health services (Matthews et al., 2006; Mishra et al., 2009; Sanders-Thompson et al., 2004), high hourly fees (Sanders-Thompson et al., 2004), and cost of private mental health care (Roberts et al., 2008). The issue of transportation also was discussed as a barrier and can be related to finances, especially in thinking about an individual's financial ability to pay for travel or a personal vehicle in order to access distance mental health services (Davis et al., 2008 and Roberts et al., 2008).

     In terms of environmental barriers the research discusses lack of resources and advertising within the African American community [re: mental health] (Hines-Martin et al., 2003; Matthews et al., 2006; Mishra et al., 2009). Lastly, in terms of institutional barriers African Americans report the complicated process of accessing services (Davis et al., 2008; Hines-Martin et al., 2003; Mishra et al., 2009; Roberts et al., 2008), limited appointment availability times in conjunction with the individual's schedule (Roberts et al., 2008), service eligibility issues (Davis et al., 2008 and Hines-Martin et al., 2003) and gatekeepers (i.e. perceived negative impact of professional' attitudes on access to services) (Hines-Martin et al., 2003).

Strategies

Solutions and strategies include providing more community-based services and interventions (Connor et al., 2009; Matthews et al., 2006; Roberts et al., 2008), providing more culturally-sensitive trainings for clinicians (Sanders-Thompson et al., 2004, Matthews et al., 2006, and Mishra et al. 2009), increasing education and awareness about mental illness (Anglin et al., 2008; Bathe & Pryor, 2011; Matthews et al., 2006; Roberts et al., 2008), creating greater alliances between spiritual and religious sectors of the African American community and mental health sectors (Anglin et al, 2008 and Blank, Mahmood, Fox, and Guterbock, 2002), enhancing education via social contact with persons with mental illness, and including mental health information as part of larger health education forums (Matthews et al., 2006).

Additional solutions include anonymous information and mental health screening, examination and improvement of interpersonal and patient care practices (Mishra et al., 2009), improvement of service options (e.g. offering walk-in) (Sanders-Thompson et al., 2004), exploration of strategies to reduce mental illness stigmas (Connor et al., 2009 and Matthews et al., 2006), culturally relevant and appropriate mental illness awareness campaigns (Anglin et al., 2008), and improved assistance in how to access mental health services (Roberts et al., 2008).

Strengths and Limitations

This literature review provided a general overview of some of the existing literature on African Americans' use of mental health services, and presented both strengths and limitations within the literature. A key strength within the literature focuses on the ages of the participants used within each study group, which accounts for differential responses based on age. The literature combined included participants from 18-90 years of age. For example, one study utilized three age groups (25-45; 46-65; and 66-85) while another study's participants ranged in

age from 25-65. Another key strength was that many of the studies used quantitative research methods, which increased the precision and generalizability of the findings. Nevertheless, there were several limitations within these cited research studies.

One limitation within this literature review is that participants were either all women or the women participants outnumbered the men participants. This can be problematic because it does not account for gender differences in mental health attitudes or provide a substantial representation of the mental health attitudes of African-American men. Another limitation within the literature review was that a majority of the studies were conducted in northern states. This could be problematic due to differential views based on individuals' originating from the north in comparison to individuals originating from the south. For example, religion within the African-American community has deep roots in the south, which in turn can play a role in how southern African-Americans view mental health/mental illness. A final limitation is that a majority of the studies used low-income African-Americans as study participants. This is a limitation in that it does not account for differences in views and help-seeking behaviors based on socio-economic status.

CHAPTER III

Methodology

The purpose of this study was to explore the stigma of mental illness within the African American community from the perspective of African American clinicians. More specially, this study examined personal messages African American clinicians received about mental illness within their family, community, and religious organizations. Data also was obtained on observations and perceptions of African American attitudes, based upon their client interactions, towards mental illness and whether a change has occurred within the past 5-10 years; identifiable stigmas within the African American community; inhibitors to African American help-seeking behaviors; variables that influences African American help-seeking behaviors; and recommendations for improving African Americans' comfort with disclosure within the therapeutic setting.

For this particular study, an exploratory qualitative research design was used to examine these variables and to gather narrative data. This method was selected not only because of the limited amount of qualitative studies found on this research topic but also because of the level of depth that such findings could provide. By using a qualitative research approach, it allowed the researcher to solely focus on developing a deeper understanding of the research topic through the subjective experiences of the study participants. In addition, the study's findings will add more qualitative depth and richness to the existing literature on this topic.

Sample

      The sample for this study consisted of nine (9) African American clinicians. Selection criteria included clinicians that: 1) self-identified as African American or Black, 2) resided within the Atlanta metropolitan area, 3) have a master's or higher-level degree in clinical social work or a mental health related field and, 4) have a minimum of two years of experience working with African-American clients seeking mental health treatment. Participants were limited to those who self-identified as Black or African American because the study both asks the participants to self-reflect on their own racial/ethnic identity and discuss the messages they received about mental health from their family, community, and religious organization, as well as messages exemplified in their African American clients. Geographic location also was limited to clinicians that resided within the Atlanta metropolitan area as a convenience measure for the researcher who drove to all scheduled interviews. Diversity in regards to age, sex, agency affiliation, and years of professional experience also was solicited.

      In recruiting the study participants a purposive non-probability snowball technique was used. After receiving official approval from the Human Subjects Review (HSR) Committee (See Appendix A for HSR approval letter), emails were sent to professional colleagues, peers, and classmates soliciting their assistance in finding potential candidates for the study. Within each email the researcher informed contacts of the purpose of the study, the criterion for being a participant, and the steps the researcher would take in responding back to the individuals they referred (See Appendix B). In addition, attached within each email was a letter for direct distribution to professional colleagues, peers and classmates', friends, family, co-workers, and

professional connections that they believed would be eligible to participate in the study (See Appendix C).

Once emails and phone calls were received from potential participants about participating in the study, the researcher responded back to each potential participant via phone. During that initial contact the study's description was reviewed, the potential participant was screened for eligibility, and participants were asked if they were willing to volunteer for participation. Upon confirmation of voluntary participation, the participants provided an interview time and location that worked best for both the researcher and participant. Focusing specifically on the proposed location of the interview, the participants were asked to choose a place that they felt was confidential, safe, and convenient for them. After the interview time and location was confirmed, an electronic copy of the Informed Consent (See Appendix D) was sent to the participant for review prior to the interview. This process continued until all nine participants were recruited.

Data Collection

The majority of interviews were held in the clinicians' private offices. On the date of the scheduled face-to-face interview each participant was given a paper copy of the informed consent, which was reviewed prior to the start of the actual interview. Participants were re-informed about the voluntary nature of participation and of their rights to refuse to answer any individual question during the course of the interview. If participants wanted to withdraw from the study they were free to do so, but were asked to withdraw both verbally and in written form within 48 hours of the interview's close. Once informed of their decision to withdraw, all their materials would be destroyed.

The confidentiality of the participants was protected by assigning a numeric code to each transcription tape, by removing all identifying information, and by keeping each participant's

signed informed consent form separate from their transcription tape. Participants also were asked to refrain from using the names of clients or other identifying information in order to protect the confidentiality of their clients. In addition, participants were informed that there was minimal risk for their participation. Examples of such risk were that they might experience emotional discomfort when asked to discuss their own perception of mental health stigma in the African American community; and some discomfort when asked to self-reflect and discuss messages received about mental health within their own personal history. They also were informed that there would be no financial compensation for their participation. Although they were informed that they may not directly benefit by participating in the study, their participation would enable them to confidentially reflect and share their own personal history and the messages they received regarding mental illness, and how those messages in turn shaped the work they do with their clients. Furthermore, participation provided them the opportunity to contribute to research intended to highlight the internal and external barriers that hinder African Americans from seeking mental health services. Once the informed consent was reviewed and signed, the actual interview commenced.

Data for the study was collected using semi-structured in-person interviews. This method was chosen to increase study validity while still allowing flexibility for open-ended discussion. It was originally reported in the HSR application that interviews would last between 45-60 minutes; however, the actual interview narratives ranged in length from 20 minutes to 58 minutes. With the participant's consent, each interview was audio recorded using a digital voice recorder. These interviews were later transcribed, analyzed, and numerically coded. All transcribed material is kept electronically secure via use of password protection. As required by Federal regulations all informed consents and audiotapes are securely locked and will be kept in

a safe location for three years. After that time, those materials will continue to be secured until they are no longer needed and then will be destroyed.

The interview itself consisted of a checklist of seven structured demographic questions (See Appendix E) and six semi-structured interview questions (See Appendix F). Each interview began with the distribution of a 1-page demographic sheet, in hopes of building early rapport that could help positively guide the rest of the interview. Participants were asked basic demographic questions that reported age, gender, discipline and credentials, agency setting, number of years in the mental health services field, number of years providing mental health services specifically to African Americans, and percentage of current caseload that identify as being African American or Black. Once the demographic sheet was completed, participants transitioned into the 6 semi-structured interview questions that asked the them to discuss perceptions about messages surrounding mental illness within the African American community; African Americans attitudes towards mental illness; identifiable stigmas within the African American community; inhibitors to African Americans help-seeking behaviors; variables that influences African Americans help-seeking behaviors; and recommendations for improving African Americans comfort with disclosure within the therapeutic setting. Participants also were encouraged to provide case illustrations, as needed. These queries addressed the study's following research questions.

1. What are African American clinicians' personal experiences with messages about mental illness from family, community and religious organizations?

2. What do African American clinicians identify as attitudes of African American clients towards mental illness? Do they perceive a change in these attitudes over the past 5-10 years?

3. What do African American clinicians identify as stigmas associated with mental illness in the African American community?

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4. What do African American clinicians identify as inhibitors to African American clients seeking mental health services?

5. What do African American clinicians identify as stimulus for African American clients to seek mental health services?

6. What do African American clinicians believe needs to happen to improve African American clients' comfort with self-disclosure within the therapeutic setting?

Data Analysis

All data from the study was transcribed verbatim and analyzed according to themes. The demographic data in this study was analyzed by using frequency distributions. The qualitative data was analyzed using content thematic analyses to describe the common and divergent themes that emerged in response to the six semi-structured interview questions. Content analysis was used to group together and record the overlapping of specific phrases and words used by the participants, without interpretation. Content analysis also was expanded and organized into categories based on emergent themes and differences. Responses in this study are illustrated through direct quotations to minimize biases by the researcher and to increase reliability and validity in data interpretation.

CHAPTER IV

Findings

The overall purpose of this study was to explore African American clinicians'

perceptions of mental illness stigma within the African American community. This chapter first

presents the demographic data of the study's participants, followed by a reporting of their

responses to the guided interview questions, and lastly a brief summary of the overall findings.

Specifically, the report of the participants' responses are organized into six (6) central categories

that are presented in the same order as during the interviews and highlight and report emerging

themes from the data, including illustrations of various participant responses. The six central

categories discussed in this chapter are: 1) messages received about mental illness; 2) attitudes

regarding mental illness and perception of change; 3) stigma of mental illness; 4) barriers to

seeking mental illness treatment; 5) reasons for seeking mental illness treatment; and 6) mental

illness and the therapeutic setting.

Demographics

The study sample consisted of a total of nine (9) participants. All of the participants self-

identified as being African American or Black and resided within the Atlanta metropolitan area.

The participants ranged from 28 to 55 years of age, with the mean age of 37. Out of the nine (9)

participants, 67% percent (n=6) self-identified as being female and 33% (n=3) self-identified as

male. Of the nine (9) participants, 44% (n = 4) held a minimum of a Masters degree and 56% (n

= 5) held both a Masters degree and a Doctorate degree. Some of the degrees reported by the

participants included Masters in Social Work, PsyD in Clinical Psychology, Masters in Psychology, and Ph.D. in Clinical Psychology.

Focusing on occupational setting, 33% (n =3) of the participants worked in a university counseling center; 22% (n = 2) in a residential setting; 11% (n = 1) in a community outreach center; 11% (n = 1) in an outpatient facility; and 22% (n = 2) in multiple facilities (i.e., inpatient/outpatient and outpatient/private practice/college counseling). The number of years in which participants worked in the mental health services field ranged from 2 years to 28 years, with the average of 12.5 years. The number of years in which participants provided mental health services specifically to African Americans, also ranged from 2 to 28 years, but with the average number of years being 11.7 years. Lastly, the percentage of African American clients on each participant's current caseload ranged from 30% -100%, with the average being 83%.

Messages Received about Mental Illness

Participants were asked to reflect upon their own personal history and to discuss messages that they received about mental illness in three (3) different areas: family, community and religious organizations. Of these 3 areas, participants reported receiving most of their messages about mental illness from their family. The majority of these family messages, whether directly or indirectly, centered on mental illness being 'private', 'ignored' or 'secretive' as illustrated by the following participants:

Participant Nine:

"…From my family, I would say personal messages that I received is that it's really a moot point. We really don't discuss mental illness or mental health services in my family. We did not."

Participant Eight:

"…It was kind of like mental illness didn't exist in our family, or that was something that we never talked about…like there was never a conversation about it".

Participant Four added:

" …My own personal experiences mental health was never mentioned in my family growing up...in my own personal kind of growing up there were no messages of any kind, other than it's a non-issue, right".

Collectively, mental illness for these three participants was seen as a private matter that was not brought up within the family. Five participants in this study acknowledged that while mental illness was something that was not discussed or acknowledged within their family, a few participants did acknowledge that it was brought up during discussion, but still not really acknowledged. For example Participant Seven stated,

"…Now that I am thinking about it, an uncle who was a vet and had been in Vietnam… and all this kind of things. So he had trauma-induced psychosis, of course. But at that point we knew that he was sick and it was always the military messed him up, type of thing. And so, that was pretty much it. So there wasn't a lot of discussion around it".

When mental illness was mentioned within the family among these study participants, it appeared to remain within the family. Participant Five illustrates:

"…It's [mental illness] something that we can work on… with, inside the family…so there was no need for seeking any form of counseling, because your immediate family can help you get through that problem…".

Participant One reported that seeking outside help (e.g. mental health treatment) was not seen as an option or was briefly discussed as a possible option but never followed through. In speaking about mental illness within the family, this participant stated:

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"On my paternal side of the family, I do have a couple of relatives, one in particular that, you know, deals with chronic mental illness. And—but I think just because of the set of circumstances around his life, people are just more supportive. But I don't think it has really increased my family's willingness to access services, oddly enough. Although they know that it's been very important in helping him stay and remain stable, I don't think that it has necessarily translated into their willingness to now go seek treatment…. even if they feel like they're going through things. We've had some tragedy particularly on that side of the family. Um… but I think all of us can agree and we have talked about it several times that at the distinct times when we really had trauma in our families, that everybody primarily involved needed to go to therapy. But nobody actually accessed it."

There was however, one participant, who was distinct from the other participants and reported having open conversations with the family regarding mental illness. This was contributed to the mother being licensed as a clinical social worker who had a private practice in the basement of their home and the father had a Ph.D in counseling. This participant reported,

"…Mental health issues were just kind of part of my growing up…it was something that was accepted, because my mom's private practice office was in our basement. Her clients came through our front door. I met a lot of them. The way it was explained to me as I was a kid, which is kind of how I explain it to my kids now, is that Mama was helping these people with their feelings"

While the majority of the participants reported that mental illness was not openly discussed or mentioned in their family, retrospectively, with their current training and education, some of the participants recognized the presence of mental illness among family members when growing up. Participant Eight stated,

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"…In looking at my family now and just the different personalities and different things, like there is definitely some type of mental illness. I'm not diagnosing anybody, but it was definitely there, but we just never talked about it".

Participant Four added,

" …It [mental illness] never came up in my immediate family or in my extended family, even though, obviously thinking back on it now, there were people in my family that suffered from mental illnesses that probably could have used some treatment".

These findings seem to suggest that in addition to mental illness being seen as a private matter that was not discussed within the family, that there also was a general lack of knowledge and understanding about mental illness within the families of this study, as evidenced by Participant Four:

"…The closest thing I had to any counseling was just high school counseling. Going to the guidance office and that was 'cause I got in trouble a few times but nothing significant. I had no idea what a psychiatrist was or a psychologist, or what they did, or even a social worker. I mean my idea of a social worker was someone who came to check the house to make sure that … you know …we were doing what we were supposed to be doing so we'd continue to get government aid. But I never thought of it as… I never connected that with mental health or mental illness. And I never knew that those were the same people that dealt with mental health issues."

Messages about mental illness received from the community were less significant. Four participants reported receiving very few, if any, messages from their community about mental illness. One participant reported "as far as messages from my community…I don't remember anything explicit really about mental illness, mental health treatment, that sort of thing"; while

another participant stated, "I grew up in the suburbs of New Jersey, so nothing really came up surrounding psychology or mental health" [sic]. However, other participants reported receiving negative messages from their community. These messages were that 'mental illness was something to be feared', that those 'individuals with mental illness are "crazy" and/or should be avoided', that seeking mental illness treatment services 'was not an option', and that mental illness was something that 'does not exist within the African American community'. Participant Eight illustrated these sentiments by stating, "I would say in the larger community, it [mental illness] was just looked down upon, like you know it doesn't happen amongst African-Americans"; while Participant Nine stated, " from the community, I would say that words like someone being crazy or I'm a lunatic. Derogatory kind of messages would have come from my community about mental health, illness, and services". Participant Seven also added,

"I had a neighbor in the neighborhood that was schizophrenic …now I know that. But back then it was that he was mentally sick. As so, it was one of those things where you just stayed away and protected yourself because he was so unstable".

Regarding religious organizations, almost all of the participants reported receiving more messages about mental illness from their religious organizations than from their community. Overwhelmingly in examining the three areas asked of participants (family, community, and religious organizations) in this study, the dominant responses came from family, religious organizations second and lastly, the community. When examining mental illness from a religious perspective, two different lenses emerged. The first lens focused more on faith and belief in God. This group of participants reported that when mental illness was brought up, or there were signs that someone was suffering from a possible mental illness, the messages received were to 'rely more on your faith', 'turn to God', and/or as one participant stated, "pray it out". For example,

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Participant One reported, "…from a religious standpoint, you should have more faith, you should depend more on God"; and Participant Six stated that, "…within the churches is the belief they can pray mental illness away". Another participant shared that in addressing any mental illness concerns that "your church family can help you deal with 'that problem'". The second lens in which participants viewed messages about mental illness from their religious organizations looked at mental illness as a "spirit". One participant stated, "it's a demon, that type of thing". Participant Eight added, "…and then in the church, I can remember times where you know it could sometimes be viewed as maybe a spirit, as opposed to just someone needing some help". Participant Nine also added, "I've heard some religious affiliations or organizations refer to demons or demonic spirits that possess certain people and cause them to act out or do certain things".

Attitudes regarding mental illness and perception of change

Participants were asked about their observations and perceptions on the attitudes of African Americans toward mental illness and whether they perceive a change has occurred in attitudes within the past 5 to 10 years. Several responses were reported. Participant Five noted that African Americans view mental illness as "something that is almost frowned upon", and elaborated as follows.

"I almost think that it's almost a joke to them. You hear people freely using the word bipolar, or they're schizophrenic, oh they're borderline and not really understanding what those diagnoses are. So I think it's just—I don't think that they take it seriously. I don't think that they believe that it's really a mental illness and if they do, I don't believe that they feel like they are affected by that. Oh, he's just being crazy or he's just being bipolar but not really understanding that that person really might have some symptoms of

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bipolar. So I think they just freely just go around saying that, but I don't really think that

they [African Americans] take mental health serious."

Similarly, Participant Nine also reported:

"With the clients I have worked with, they do not want to claim it. They don't want to

participate in counseling, don't want to take medication, and don't like the thought of

being on medication for the rest of their lives."

Participant Five spoke about how "…many black folks view mental illness as being primarily a

spiritual and not a psychological issue". This participant further explained:

"… [African Americans] don't think, oh I'm depressed, I need to go to a psychiatrist and

get medication and then go get some counseling. You think I need to go to church and I

just need to kind of shake this devil off or shake this demon off."

This participant further added personal thoughts by stating that:

"…I do think that there is some truth to the idea that mental illness is spiritual, because if

you believe in spirit, then everything is spirit, ultimately...And so anything that manifests,

particularly as it relates to the human condition, has to be spiritually based. And so for us,

us as black folks, African Americans, we've intermixed this idea of religion and

spirituality; that for us traditionally as a community, we don't separate those two things.

It's the intellectuals that separate those things, who look at spirituality as being separate

from religion. But for many of us they're one and the same".

Participant One spoke about the attitudes African Americans have about seeking mental

health services, as it relates to mental illness, and how it is seen as a "last resort". This

participant explained "…I think it's still you go later when things have gotten worse, instead of

kind of seeing that this is the issue or this could be a potential issue and it's kind of starting

early". Participant Two supported this by adding, " …for African-descended clients it has to get really, really bad before they come to therapy". Participant Two also spoke about African Americans' attitudes about mental illness as a sign of weakness, and explained "…specifically with my African-descended clients I just feel like the notion is that they're not strong enough and that's why here." In specifically speaking about work with student clients, the participant made an interesting notation:

" …What I've noticed with my student clients more so is that they haven't received as many explicit messages that therapy means that you're weak, mental health treatment means that you're weak. It's more been an implicit notion that if you cry about things, that means that you are weak."

In discussing whether or not participants perceived a change in the attitudes of mental illness over the past 5-10 years the majority of the participants reported that they believed there has been a slight change, but insignificant. Participant One reported that, "…I think it's improving. It's getting better and it's getting more commonplace. I think it's becoming more acceptable". In talking about African Americans attitudes in seeking services the participant further stated "…I think that piece may be there of just making the appointment and showing up for the appointment…but having that commitment of continuing to go…I don't know that is happening so much". Participant Two concurred by adding, "I would say there has been a change…in terms of how African-descended clients view therapy, medication, counseling, and coaching. I think there has been more openness to it". This participant also added, "I don't know if that's because there's an increased respect or value for the field or it's because of more exposure. I feel like it is because of more exposure to mental health and to therapy." In addition, Participant Seven added " as it relates to the black community, I would like to believe yes we

have gained a sense of knowledge, being more accepting or inviting to get professional help",

while Participant Eight added " I just think that it's more accepting. It's more like mental illness

in the community is treated like someone has cancer. It's not like you've been diagnosed, now

what's the treatment for it".

In further discussing and acknowledging the slight change in attitudes, one participant

also contributed the slight change to the increase of Black clinicians in the field (even though

they spoke about the continued need for more Black male clinicians) while another participant

spoke about the increase of cultural competency training and outreach efforts. While the majority

of clients acknowledged there is a slight change, the degree of change still remains insufficient

enough to bring freedom and comfort in seeking mental health services. Furthermore,

participants still brought up the continued existence of stigma within the African American

community and how despite the slight change in openness to treatment there is still the reality of

a lack of follow-through and/or continuing of mental health services.

Stigma of Mental Illness

After exploring attitudes regarding mental illness and perceptions of whether there has

been a change in attitude over time, participants were asked to identify the stigmas that they

associated with mental illness within the African American community. The two most

commented stigmas that the participants reported were "crazy" and "weakness". When

discussing the term "crazy", Participant Seven reported, "I think some of the stigma is, if you

have a mental illness, you're crazy". If you go to counseling, you're crazy". Participant One also

noted the term "crazy" and spoke about a particular client that was directed to the counseling

center by mistake, and shared that there was this assumption "if I come over here and talk to you,

that means I'm crazy. And the client was like I'm not crazy". Participant Three also remarked

that "the biggest one is it means you're crazy, whatever crazy means". They further explained by referencing an experience with a former client stating that, "she was very concerned that she was crazy, that I was going to say that she was crazy, or people would perceive her as crazy". Participant Eight also remarked,

"I mean definitely using the word crazy as opposed to you know—because crazy just kind of puts you off in like a small pocket of society. And so just that whole negative stigma, calling people crazy as opposed to just calling it what it is…"

In addition, many of the participants spoke about the term "weakness" as another common stigma associated with mental illness within the African American community. More specifically, when discussing the term "weakness" participants spoke about it both in a spiritual and non-spiritual sense. For example in discussing "weakness" in the non-spiritual sense, Participant One discussed how there is that perception that if you go to seek counseling services it means your weak. This participant further elaborated by stating it means that, "you can't handle your situation, that you're maybe responsible [or] that you don't have the inner strength to deal with whatever on your own". Participant Three also noted that "… a lot of times there is a sense that winding up talking to a therapist means that you are weak, that they couldn't will themselves out of this". Interestingly enough, when a client expresses these stigmas this participant reported asking them to compare mental illness with the flu. In other words, the participant would ask the clients if they had the flu and were in bed as a result, would people say they were weak because they could not will themselves to get out of bed, as a way to "challenge" their thinking and elicit a discussion.

Other participants drew connections between "weakness" in the non-spiritual sense and gender. For instance, Participant Four reported viewing weakness as the number one stigma and

spoke about how African Americans, especially men question what it says about them if they go to someone (i.e. a therapist) to talk about their problems. The participant further elaborated by speaking about experiences working in the counseling center at a predominately African-American male college and how there is "that notion that I'm weak if I go there [counseling center], I've got to handle this myself". The same participant also spoke about how this stigma also affects [African American] women and that idea that they believe that they should be able to work it out themselves. Speaking more specifically about African American women and weakness as a stigma associated with mental, Participant Two introduced the term "superwoman complex". This participant elaborated by discussing how with a lot of Black female clients there is notion that they are supposed to manage all these different things and the internal struggles they experience. If it is perceived that they [women] are unable to deal with these difficulties and turn to therapy, then therapy further confirms their inability to manage challenges. In elaborating, this participant spoke about a client who went through moments of ambivalence about what it means to share within the therapeutic setting because of her perception of "being strong not only for the masses but also viewing herself as being strong for other black women".

On the other hand, participants also spoke about "weakness" as a stigma in the spiritual sense or as one participant reported "that in this feeling of weakness there is a faith aspect…that their prayers weren't strong enough or their faith wasn't strong enough". Participant Two also discussed spiritual weaknesses by stating,

> "That you're not as strong in your faith as you should be, because if you really believed in God and really utilized God, and through your faith relationship the way that you should be and the way that's most beneficial, you wouldn't need to come and talk to some stranger kind outside of the family".

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Participant Three added:

> " I've had a lot of African American clients come to me and see coming to a therapist as
> in some ways like a failure of their faith. In a lot of cases they've been praying that Jesus
> would take away their panic attacks or take away their addiction or whatever it is. Often
> times they were told very explicitly by parents, grandparents, pastors, church elders that
> if you pray hard enough and if you're faithful enough then God will take this burden from
> you".

For the participants, there seemed to be a connection between stigma and religion/spiritualty and how it is viewed in the African American community. Overall within the African American community, there appears to be a 'negative stigma about mental illness that remains dominant'. Other stigmas that participants discussed included the 'association of mental illness with homelessness and criminal activity', that "you need medication in order to deal with it [mental illness]"; and that "if you have a mental illness you will be automatically labeled". Additional stigmas spoke to the overall concern of 'fear'. In other words there is that 'fear of being labeled', 'the fear of being placed on medication', and the fear of "being an individual with a mental illness".

Barriers to Seeking Mental Health Services

Each of the participants was asked to discuss their perception of what inhibits African Americans from seeking mental health services. Some of the participants spoke about the overall "treatment history" of African Americans within the United States. More specifically participants spoke to the history of institutionalized racism and the treatment of African Americans within the healthcare system. This treatment in turn, according to some participants, created a mistrust of

the system and a concern for how African Americans would be treated if they were to seek services. According to Participant Two:

> "…There is a very realistic piece of the mistrust because historically in psychology non-white folk have been quite, um … I don't know what the word is or a clinical or nicer word...but have done things to be mistrusted or to be distrusted … in terms of how psychology has anthologized African descent psyche, culture, paranoia…"

Participant Six spoke about institutionalized racism and the experiences of African American clients:

> "There is already with society this underlying racism, that our clients come in and they feel that racism … it is very real…and so that is one of the reasons why [our organization] came into existence, to actually try to meet the needs of the African American community that are being underserved due to this underlying racism, that I'm not the right color to get the help. And they'll see white America gets insurance, go right to the doctor and get a prescription and they go in and they get told, well you don't meet the requirements. You don't have this and that and they're left…And so in their mind because I'm African, it's not because they're African American, it's because they don't come to the table with everything like White America does…And so they come to the table with that barrier of, oh yeah they don't say [it], they're waiting for somebody to say, it's okay to be black and be here".

Participant Four spoke more specifically about African American men and their history of treatment,

> "…There is kind of this general mistrust that you have to get past, particularly with black men that's real. And you have to treat it seriously not as a kind of like this paranoia,

which was very common looking at that history. There was a misdiagnosis of many black

men, particularly during the 60's and 70's, as being paranoid schizophrenic. And so

there's a healthy cultural paranoia that comes with being a black man, being a black

person in general, but being a black man especially in this country, that if you don't have

it you are susceptible to fall prey to the system.

So there is a paranoia that you develop, you get on the elevator…and there's a

white woman on the elevator and it's just you and her. It's in the back of your mind, this

white woman's probably afraid of me, so she's going to make a little conversation, she's

going to clutch her purse…there's things you expect. And some people will call that

paranoia, right. Clinically, we'd say well why are you so concerned about this? Why are

you so paranoid about how people are perceiving you or that they are afraid of you? But

that's real. And that comes from generations and generations and generations of things

happening, of people being lynched for not stepping off the sidewalk or for whistling at a

white woman. You know not saying the right thing when asked certain questions. I mean

this is real, this is palpable. It means there's been a real history of terrorism in this

country as it relates to black folks, post enslavement."

While some participants spoke to "… the mistrust of virtually all of the social systems in

this country … and that's from just years of abuse and oppression", many of the participants also

spoke to finances and lack of knowledge as being a major barrier. When discussing finances,

participants spoke about "… not being able to afford certain counselors or mental health services

that are not free or that are not offered on a sliding scale based on income". They also spoke

about the assumptions that many African Americans have about finances that prevent them from

seeking services. In other words "…many African Americans think that therapy, psychotherapy

in particular, or seeing a psychiatrist is more for the rich…the wealthier, the rich and the more privileged". In talking about finances, Participant Six, thought about personal clients and spoke about it extending simply beyond not being able to afford services at a given time:

" …The majority, 92%, of the clients that I served in the past 20 years, poverty is no job…and so poverty for them or what I'm speaking about is having no income, relying on the system to really navigate life…so we are dealing with clients that are indigent, they have nothing".

Participant Two spoke not only about "the financial resources piece that comes up a lot" but also about the challenges experienced as a clinician setting up client fees in private practice, knowing that many African Americans "don't have the money for that". This participant stated:

"I have a struggle just internally in terms of me having a private practice … and the value in terms of me having a private practice … and the value in terms of my services and how I charge versus wanting to work with a certain population who might not understand the value and or who just basically might not be able to pay it. So what does that mean for me sticking to my fees and respecting myself as a clinician…"

In discussing lack of knowledge as a barrier, participants spoke about it in several different contexts. One context is African Americans not seeking services due to lack of knowledge about what constitutes mental illness or what requires treatment. As illustrated by Participant Three,

 "So the only kind of perception they have of who goes to see a psychologist is the schizophrenic on the street who is talking to himself and hallucinating, right. And so I'm depressed, I'm not that or [not] having panic attacks...They don't have really … oftentimes a conception of someone that's basically well-functioning or decently

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functioning, but has some areas they need to work on. That's not in their mind who'll

wind up in therapy.

Participant Four spoke about how African Americans view mental illness and accessing mental health services as being a "mystery".

"…So the idea of saying to someone, you know you need to be in counseling, you're

depressed, so like okay what are you going to do for me? It's like it's a mystery, like how

does that really work? So if you're in a profession you understand techniques and skills

that we use to effect change in people. But if you're not in the profession, it may seem

like witchcraft, like what exactly are you guys doing in there? How is that you can take

someone who is severely depressed and then help them to not be depressed. What is the

mechanism by which you do that? And so I think that there is a mystery around what we

do…."

A final context that a couple of participants spoke about addressed African Americans " not knowing where to go, not knowing who to talk to, and not knowing what resources are out there". To further illustrate, Participant Seven discussed the barrier as "…not being aware of all the different levels of care that is available. Not being aware of the positive outcomes and effects of therapy, medication or just therapy".

A final barrier that some of the participants spoke about focused on the overall concept of fear. Participants spoke about the fear of being "misdiagnosed", "labeled", and/or simply being "put on medication". According to Participant One there also is "…the perception of how they think others will view them because they're going [for mental health treatment]."Participant Nine added the connection to the stigmas associated with mental as a barrier to seeking out mental health services.

"…Fear of being associated with a disease, the stigma of having a mental illness. Kind of that you are all the way to the right, just like psychotic…the image of someone who hears the voices…hallucinates…the appearance of that's what a mental illness looks like…"

While the participants in this study predominately spoke about the history of African Americans' treatment within the United States, finances and lack of knowledge, and fear as barriers to seeking services, a couple of the participants addressed additional barriers. For example, Participant Five spoke about family and how family and messages received from family, in general, are a barrier for many African Americans in seeking therapy.

"I have a cousin I haven't seen her in your two years, but I've just been kind of hearing how she's been unraveling. She got upset with her mother and she started living outside. And this is a 45-year old woman. She started living outside in the backyard and she's saying that the job that she has, she makes $45,000 day. So clearly, things are not going well with her. I don't know all the symptoms because when I ask my family about it, they just kind of brush it off like she just out there, just being crazy….So as our family, we should be able to help her and everyone in my family is like oh no that's what you call it, just being crazy…So I think just because of our upbringing and how taboo it's been in the past, we're just not going to seek out no services".

This same participant spoke further about the role of keeping family issues within the family as a barrier to treatment:

" In our community we have [a] tendency that what goes on in our house stays in our house. And so don't take that outside, it's kind of like a betrayal if you're saying that something went wrong in your childhood or something went wrong in your household,

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then you're pretty much talking down on your family, talking down on your parents and that's just disrespectful…and so I think a lot of times people don't seek help because…it's been ingrained to keep it within house."

A couple of participants spoke about 'prior bad experiences' being a barrier to treatment. For instance, Participant Nine reported:

"…Some [clients] have participated in counseling, sought mental health, or been referred to mental health counseling and had a bad experience. And so that just deters them from ever trying it again or trying to trust anyone else".

Lastly, participants spoke about the "lack of access to services that are culturally competent" and "the lack of therapists and clinicians that can definitely relate...from a cultural and diversity standpoint minority model" as being barriers for African Americans in seeking out services.

Reasons for Seeking Mental Health Services

Participants were asked to identify what they perceived influences African Americans in their decision to seek mental health services. In discussing the different reasons that ultimately influence African Americans to seek mental health services, three distinct forms of external motivation were most reported by the participants in this study. First, participants reported, "if they're legally or court mandated to go" as being the most predominate reason. In other words, "they're mandated to go by somebody whether it's DFACS (Division of Children and Family Services) or for any kind of court reason, custody or criminal activity". While most of the participants referred to "legal" or "court-ordered" mandates, Participant Six also spoke about mandates from other sources. This participant also acknowledged that "legal mandates is where

we see most of our people" but also spoke about mandates placed on clients from the housing authority as a reason for seeking services, as illustrated below.

"In their minds there's nothing wrong. If you leave me alone and pay for my housing, I can smoke enough marijuana and it keeps me stable. I feel normal. I take some heroin and I'm normal. So I don't need that and just pay for my housing. Housing is saying 'oh no' you have a mental illness and in our mind in order for you to even maintain the apartment you have to address your mental illness. So in order for us to pay for it [rent] you need to go seek treatment. And so that's what we're seeing is the motivating factor…".

Participant Five spoke from a residential standpoint:

"In my line of work, it's because they're mandated to do it. It's a requirement. Here it's a requirement that you receive services. You get all of the assessment that you need and they have to follow the recommendation of the mental health team. If you have no diagnosis, you don't have counseling. If you have a diagnosis, you have counseling...And so it's because they're forced to do it".

Secondly, participants identified influence (positive and negative) and personal testimony from family and friends as primary reasons. They reported either, "family and friends probably saying 'look you're not doing alright, you need to go'. Maybe, they've tried to help and say I don't know what to do with this, you need to talk to a professional"; or "if someone else they know, someone in their family had a good experience with therapy or seeing a psychiatrist, they'd be more likely to go"; or because " a spouse threatening to leave because they're fed up". Furthermore, participants noted that while the personal testimony of family and friends is a large factor in their reasoning to seek services, they also highlighted that whether or not African

Americans have a good rapport and/or trust the individual giving the testimony is just as important.

Thirdly, participants reported that many Africans Americans are influenced to seek mental health services as either their symptoms/problems "got out of control" and/or because seeking services is a "last resort". Participant Four illustrated this by briefly talking about prior work at Veteran's Affairs (VA) and how when the clients finally come in, "they had done considerable damage to themselves". Participant Nine expanded,

> " If some kind of consequence has occurred for whatever the range of the situation could be so they kind of feel like they have to do something. So some people kind of have a meltdown, some people end up getting arrested, or something had occurred that forces them to finally seek help".

Participant Two reflected on clients served and reported:

> "…I feel like for African-descended clients it needs to get more crisis mode for them to come in, as opposed to something being preventative or a space where they just want to learn more about themselves and kind of build some tools. They're coming in when stuff has hit the fan, basically. That's what I notice more…And it's just like why didn't you come in six months ago, kind of what did it mean now. It's just like now I can't take it…now I'm out of work because I've been so stressed out, I can't go to work. Now I'm skipping class, now I don't want to do this, I'm not functioning in this way. It gets to a deeper level of non-function, that's when it would be more likely to bring them into the door, which is sad, but which again I understand in terms of the stigma … and in terms of the stigma and in terms of financial stuff".

As for the participants in this study, three predominate reasons were identified that influence African Americans in their decision to seek mental health services – legal mandates, external influence and loss of control. External motivation appeared to be at the root of African Americans seeking out mental health services.

Mental Illness and the Therapeutic Setting

The final question asked of study participants was, what they believed needed to happen within the therapeutic setting to improve African Americans' comfort with disclosure. For many of the participants they spoke about and stressed relationship building as the key factor for a meaningful therapeutic relationship. More specifically, participants stressed the importance of building rapport and being genuine/real with the client, addressing and stressing the importance of confidentiality, and clinicians being more transparent (i.e. increased willingness to self-disclose, bringing the "elephant" into the room, etc.).

In discussing the importance of building rapport and being genuine, Participant One stated:

> "I can't speak for all African American people, but I think just establishing some type of common ground that you really care. You don't have to know everything that a person's been through, but that you are empathetic … what I'm going through and not … going to be judging. And that you're going to be for real with that you're saying to me. You're not going to be bs-ing me…those interactions with a therapist I think goes a long way."

Participant Four also acknowledged that, "rapport is probably one of the most important things that you can develop, with the context of counseling…" but also expanded by discussing the importance of being genuine,

"…You have to figure out a way to be very genuine in the moment and I think that's extremely, extremely important particularly with African-American males, but with African Americans in general. That as long as they realize that you're a real person, and that you're there and that you're committed to whatever it is that you're doing with them, that that's what makes the difference. And so I think disclosure happens as a result of being real, in the moment, and genuine."

In terms of confidentiality, many participants referred back to the stigmas regarding mental illness, the mistrust of the system, and messages African Americans received from their families (e.g. "what goes on in our house stays in our house") that affect African Americans ability to self-disclose. Therefore, there is the need to stress with African Americans that what you are disclosing to me will be kept confidential, that I will not be using what you tell me against you later (with exception, i.e., abuse), and that there are consequences for the therapist if confidentiality is broken inappropriately. Participant Five reported work with court ordered individuals:

"They need to know that even if you are mandated to receive services that what goes in the session stays in the session, of course unless you present harm to yourself, someone else, or report abuse, and they know that has to be disclosed. But just to know that when you get subpoenaed to court that the conversation that you and your therapist had was privileged communication and I'm not going to disclose that, because I can't disclose that. And once they see that…[along with the development of trust]…they'll just tell you their life story…"

Participant Six spoke about the "importance of educating clients on confidentiality" within the actual therapeutic setting and provided an example of how this is done with clients.

> "The way I do it is, pretty much cite the CFR-42, stating as far as what can happen to an agency and a clinician. I say to them if I violate your confidentiality and you take me to court and win, I have to pay you $25,000 and if I have to pay you $25,000 that means when you sue the agency, you'll win that. And they've got to give you $250,000. So if they got to give you $250,000 they're going to tell me you broke confidentiality … here's your pink slip. You got to go. And I need my job. So if nothing else, I'm going to protect your confidentiality so I can keep working here. And I've never had a client that said well that's not what I wanted to hear. They smile and they go, okay I believe you".

Finally, in terms of transparency, participants spoke in terms of clinicians being more open about themselves and willing to self-disclose as a way to show the client more of how they are. As Participant Three reported:

> "In the therapy session, I myself do a lot of self-disclosure. I kind of feel like there is, of course, a power dynamic that's set up where I'm asking you to disclose your deepest most personal things about yourself. But I'm going to be a completely closed book…and you know I never thought about it this way but that's kinda of why I do that especially with African Americans, and I think that we are way more sensitive to that kind of power dynamic in being … you know … un-empowered in this relationship where I'm being vulnerable to this person that I don't know. And so I almost feel like it's kind of unfair for me to ask them to open up in that way and me not give them anything of myself".

Participant Two further elaborated by talking about transparency with clients.

> "I'm very transparent, I allow my clients to ask me questions and I know a lot of
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> therapists don't do that. I allow them to ask me questions about myself professionally or
>
> personally and I make the decision of whether that feels comfortable or kind of
>
> uncomfortable…I allow them to ask those questions because I recognize that there is an
>
> inherent imbalance in the relationship and I think that it is so important in working with
>
> Black clients to not try to make it egalitarian, but to make it collaborative".

However, Participant One spoke about "self-disclosing at a point if it's something that
makes sense therapeutically". This participant further added, "…You have to check yourself.
Why are you talking about yourself in this situation? But if there is a therapeutic reason to do so
and you do that, I think that particularly helps us, African Americans in particular".

Along the same lines of transparency, participants also spoke about the need for
clinicians to "bring the elephant into the room". As Participant One further noted:

> "If a person is a different ethnicity or whatever, bring it up. A lot of times people say it's
>
> not an issue or whatever, and you just keep right along. But I think it opens the gate up so
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> that at some point or another if they do want to say something, they can come back".

Participant Two reflected and spoke about "going there with clients" as a way to increase self-
disclosure among African Americans.

> "I think that I've been able to increase retention of black clients as opposed to potentially
>
> my non-black colleagues because I'm willing to go there around the racial stuff in a way
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> that I feel like my non-black colleagues are … maybe much more worried about
>
> offending clients or not knowing what language to use".

That same participant also stressed that beyond just "going there" with your client, there is an importance in having "cultural sensitivity" and "grace, not a finesse, but grace" in addressing racial dynamics with clients.

"I've got a non-black colleague whose client talked to them about how she'd had some angry outburst at work. My therapist colleague said to her, you know it sounds like the angry black woman complex. So she's presenting this like a case conference…and my questions were geared towards was that appropriate for you to say or even a black therapist to say. I would wait for that language to come from my client first. Yet, I recognize for her that was her way of trying to go there. Client never came back. That again was her way of going there but can there be some more grace, some more cultural sensitivity around what does it mean for a white therapist to bring up an angry black woman complex when somebody is coming in wanting to be heard about assumptions being made about her or about feeling limited or kind of pushed against the wall".

In addition, to participants speaking about and stressing the importance of relationship building in the therapeutic relationship, participants also spoke about the importance of educating clients about mental illness and dispelling the myths surrounding it, within the actual therapeutic setting to help increase African Americans' comfort with self-disclosure. As Participant Eight illustrated:

"…Having open conversations and just letting people know you're not alone, you're not the only [one] that that feels like this, and you're not the only [one] going through these issues and there's help. So just have conversations about it and kind of dispelling those myths about mental illness...And because I think that you can't even scratch the surface if you don't understand what it is. You're not even going to open up your mind to anything

else, like somebody sitting down and talking to you about certain things that you don't

even have a grasp of what it is…just opening up that door, that avenue for people that

may lack for a better word, been ignorant in that area before."

Participant Two further reported about "frequently giving my clients readings about different

things" while Participant Four shared attempting to take the "mystery" out of mental illness

during work with clients.

"I say look, we don't have magic wands and we don't have pixie dust. There are no easy

answers for the issues you are presenting with. But we are very skilled at what we do and

the techniques we use are rooted in research and rooted in theory. And together we work

in a partnership to move towards a resolution and make things better…so just

acknowledging … that I think is really important and improves people's comfort".

While participants in this study mainly spoke about stressing the importance of building

the overall actual therapeutic relationship and the importance of educating clients about mental

illness and dispelling the myths surrounding it, a few other thoughts were shared about what

needs to happen to improve African Americans' comfort with disclosure. These thoughts

included the need for "more clinicians that either look like the client or that have received a lot of

training with how to be with someone that looks different"; the recognition that "what may work

for someone that may be of the privileged race, may not necessarily work for a minority"; and

the need to be "creative around how we approach people". For example, Participant Seven

reported:

"…Saying what brings you in today may not work for someone coming from another

community. You may approach it in a sense of what's going on in your world or tell me

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about your last couple of days…you just have to be able to have the ability to be flexible, switch gears, change hats, and know your client".

Summary of Findings

In summary, the findings of this study suggest that most of the messages received by participants in this study about mental illness came from their family, second to messages from their religious organizations. In messages received from their family, the participants reported that mental illness was not something that was openly discussed, if at all, and that if brought up all discussions would remain in the family. In terms of their perception about the attitudes African Americans have about mental illness, participants spoke about African Americans almost frowning upon and seeing mental illness as a joke, seeing mental illness as a spiritual issue, seeing treatment for mental illness as a "last resort", and seeing mental illness as a sign of weakness. While participants did report an overall slight change in societal attitudes over the past 5-10 years, they still acknowledged the prevalence of stigma regarding mental illness within the African American community and the lack of follow-through in actually accessing services is still relevantly high. When discussing the stigma of mental illness, participants acknowledge that it is something that still prevails and has a negative connotation within the community. The two most common reported stigmas about mental illness were "crazy" and "weakness", and the participants also duly noted the stigma of fear. In terms of barriers to accessing services, most of the participants spoke about the history of African Americans' treatment within the United States, finances and lack of knowledge, and fear as a whole (e.g. fear of being misdiagnosed). Participants also acknowledged the role of family, "bad" prior experiences with the mental health system, and the lack of Black clinicians or culturally competent clinicians within the field as barriers for African Americans in seeking services. When discussing their perception of what

influences African Americans in seeking services, participants identified court or legal mandates, the influence and personal testimony of family and friends, and symptoms/problems "getting out of control" and/or 'all other options have been exhausted', as reasons. Finally, in regards to the participants' perception of what needs to happen within the therapeutic setting to improve African Americans' comfort in disclosure, participants spoke about the overall development of the therapeutic relationship, the need to discuss and stress the importance of confidentiality, and the need for more transparency in therapeutic relationships.

CHAPTER V

Discussion

The overall purpose of this study was to explore the stigma of mental illness within the African American community from the perspective of African American clinicians, and to explore how stigma influences help-seeking behaviors in African Americans. More specially, this study examined personal messages African American clinicians received about mental illness within their family, community, and religious organizations. Data also was obtained on observations and perceptions of African American attitudes, based upon their client interactions, towards mental illness and whether a change has occurred within the past 5-10 years; identifiable stigmas within the African American community; inhibitors to African American help-seeking behaviors; variables that influence African American help-seeking behaviors; and their recommendations for improving African Americans comfort with disclosure within the therapeutic setting. This chapter highlights key findings from the literature review, compares and contrasts these findings, and explores the study's implications for social work practice. Recommendations for future research in this area are also offered.

A key finding of the current study was the significance of the role and influence of the family within the African American community. This was reflected in the participants' discussions surrounding both their personal messages about mental illness received from their own family, and those messages reflected in their client interactions. While also asked about messages received from their community and religious organizations, family messages

consistently ranked primary followed by religious organizations, then community. Influence by community messages was not a weighted concern for the participants in this study. Some of the direct and indirect messages received from their family were that mental illness is a 'private matter', 'ignored' or 'secretive'. In discussing what inhibits African Americans from seeking services and what influences African Americans to seek services, participants once again directed connections to the family unit. They discussed how messages from family such as "what goes on in the house stays in the house" and how speaking about family issues outside of the home is seen as a "betrayal" by the family are barriers for African Americans in seeking services. This may suggest that the rules of the family and family loyalty are sacred within the African American family, and that what family members think leaves an imprint on its members. This may infer that when family members are supportive of help-seeking behaviors and or when mental illness is viewed as treatable and not shaming, its members would be more likely to seek mental health services. Some of the literature review was consistent with these findings. For example, Matthews et al. (2006), Mishra et al. (2009) and Sanders-Thompson et al. (2004) also found the need to keep family information private and resolve family concerns within the family or "in house" as a prominent cultural belief within the African American community. Mishra et. al (2009) also reported the preferences of African Americans to receive mental health information from a trusted source (e.g. a family member). In addition, participants reported that knowing individuals who had positive results from counseling or hearing positive personal testimonies from family would have a positive and supportive effect on help-seeking behaviors. These individuals likely would be less threatened and fearful of mental health services and would more likely seek such services, if needed.

Another important finding of the study was the degree that African Americans hold negative attitudes and stigma about mental illness. Participants reported that African Americans frown upon mental illness, or see it as a joke; that mental illness is something that no one wants to "claim"; and that having a mental illness is a sign of weakness. For African Americans, mental illness seems to be associated with negative labeling. These findings support research by Connor, Koeske & Brown (2009), Matthews et al. (2006), and Sanders-Thompson, Bazile & Akbar (2004) that also showed that members of the African American community tend to have a negative attitude/response to mental illness. However despite these shared findings on negative attitudes of African Americans regarding mental illness, some participants in the study did acknowledge that there has been a slight positive improvement in attitudes about mental illness within the past 5-10 years, especially as it relates to openness around seeking mental health treatment.

This study's findings did note that a 'negative stigma about mental illness still permeates within the African American community'. This was evident in the use of terms such as "crazy" and "weakness" as being very prominent. For example, when talking about the term "crazy", some participants cited, "I think some of the stigma is if you have a mental illness, you're crazy" or "if you go to counseling, you're crazy". This finding is both consistent with the literature that addresses stigma and with the dialogue expressed by the women at this researcher's 1st year internship, which inspired the current research.

The final important, if not most interesting, finding of this study was that participants reported and stressed that 'relationship building' is the key factor for establishing a meaningful therapeutic relationship with African American clients. This is particularly noteworthy because 'relationship building/building rapport' with clients is among the first social work

communication skills learned, and is known to be a key therapeutic element in working with any client. Yet the participants in this study are reporting that it is a top need when working specifically with African American clients. They further stated that African American clients need to feel heard, that they matter, and that what they have to say is important. What these findings seem to say is that if the African American client does not feel comfortable in the therapeutic relationship, it will not progress. The participants in this study were adamant that when working with African American clients it is important that clinicians build rapport with them, express genuineness/realness, establish trust, and display some form of transparency if they ever want to be successful in their therapeutic work with African American clients. Participants also were adamant about the need for clinicians to stress the role of confidentiality and to assure their African American clients that their confidentiality is protected. This is consistent not only with African Americans' need for trust and privacy but also with the overall stigma of being associated with "mental illness". Secondary to 'relationship building/building rapport' and the assurance of confidentiality were the recommended need for more African American clinicians in the field, and for more culturally competency-trained clinicians, which also is supported by the literature review.

While the most consistently reported findings focused on the role of family, attitudes and stigmas regarding mental illness, and relationship building within the therapeutic setting, there were several other substantial findings. For example, the role of religion and spirituality was a prominent theme, which is supported by much of the research on mental illness within the African American community. Participants spoke about mental illness as a spiritual issue rather than a psychological issue - spiritual weakness as a stigma of mental illness and mental illness is a failure in one's faith - as commonly reported attitudes among African Americans. Some

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African Americans also held the belief that relying on God, faith, and/or church is an alternative coping method to seeking out mental health services.

Another noteworthy finding of this study was the reported need for mental health education to occur within the actual therapeutic session, a finding new to current literature. The majority of the literature speaks about the need to educate African Americans about mental illness within their community and having more culturally-specific tailored messages and outreach efforts. While the participants in this study agreed to these methods, they spoke more vehemently about the importance of educating African American clients about mental illness and working to dispel the myths surrounding mental illness within the actual therapeutic setting. This is important because through this process they also learn about the benefits of mental health services and hopefully become more engaged in treatment. Then once engaged, not only will African Americans most likely continue with treatment until completion but they may also subsequently share these experiences with others and ultimately demystify the fears of mental illness.

Other findings of this study addressed barriers found in the literature review such as lack of knowledge/awareness about mental illness, finances, and cultural mistrust/history of racism. Legal and court mandates was reported as a top reason that influences African Americans to seek mental health services. Similar to these mandates are other sources such as housing authority mandates or drug treatment program enforcement. These latter findings seem to state that in order for some African Americans to receive mental health services, an intervention (e.g. court order) has to occur either directly or indirectly prior to seeking services.

Implications for Social Work Practice

This study was able to explore various aspects of mental illness within the African American community from the perspective of African American clinicians. As a result, several implications for social work practice emerged. First, social work educators, clinical supervisors and social workers and practitioners should address issues related to stigma throughout the teaching/learning environment and remove it as a 'white elephant' in the therapeutic setting. As strongly recommended by the participants, bring the issue to the forefront rather than ignore its presence. Second, they should acknowledge that there are barriers to African American help-seeking behaviors and that these barriers need to be discussed in the family, church and the community. Furthermore, the school social worker, outreach worker, family therapist and community organizer have direct segways into the community, and can implement ways to better address stigma about mental illness within the African American community.

Third, family can serve as a motivator to seek mental health services or as a barrier to services. This, as a result, highlights the need for social work clinicians and/or mental health professionals to view their African American clients not merely as an individual client, but also as a member of a family unit. Therefore it is important for clinicians to work to understand the role and impact that their African American clients' families have on their client's therapeutic journey and how that shapes their clients' thoughts and attitudes regarding mental illness. Furthermore, it highlights the needs to find ways to better engage family members in the therapeutic work.

Fourth, based upon the perceived connectedness between mental illness and religion and spirituality, it highlights the need for social workers and mental health professionals to better understand how religion and spirituality impact the work they do with their African American

clients. It also highlights the need for exploring how to better develop partnerships between those providing spiritual guidance or leadership and those who provide mental health services to better meet the needs and concerns of the African American community. This implication largely speaks to religion and spirituality acting as a barrier for African Americans in seeking out services. A final implication for social work practice is the need to explore alternative approaches to establishing relationships with African American clients within the therapeutic setting, an implication based on findings that establishing a comfortable, trusting, and transparent therapeutic relationship was a top factor for improving African Americans comfort with self-disclosure. As one participant in this study reported, there is a need for more "creativity" in approaches used to connect with African American clients and a recognition that the approaches used for a client of the privileged race may not work for African American clients.

Suggested Recommendations for Future Research

Two suggestions are recommended for future studies in this area. Future studies should include a larger, more diverse study population in relation to gender, age, degree, years of experience, location and type of work setting. These demographics are important to obtaining a more, generalizable sample population that is more accurately representative of African Americans nationwide.

A final suggestion for future research is to focus on specific ways for decreasing the negative attitudes and stigmas about mental illness within the African American community. Much of the literature has spoken about community outreach efforts, more culturally tailored messages, more culturally competency trainings for clinicians, and the creation of greater alliances between spiritual and religious sectors of the African American community and mental health sectors. Future research on this topic should explore more specifically on WHAT

implementing these recommendations would look like. What steps might need to be taken to make that happen; and how those initiating this process would engage members of the African American community in these efforts. The recognition of these needs is definitely important and a step forward in better servicing African Americans. We have to be careful, however, that these actions are being done or else we run the risk of remaining stagnant in our goal of better addressing the mental health needs of African Americans.

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Appendix A

Human Subjects Review Approval Letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

January 24, 2013

Rabi'ah Jamar

Dear Rabi,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Vice Chair, Human Subjects Review Committee

CC: Narviar Barker, Research Advisor

Appendix B

Friends and Colleagues Recruitment Letter

Dear Friends and Colleagues,

I am currently working on my thesis as part of my graduate requirements at Smith College School for Social Work, and am currently seeking participants for my research study. I am exploring the stigma of mental illness within the African American community from the perspective of African American clinicians. I am seeking self-identified African American or Black clinicians residing within the Atlanta metropolitan area that have a master's or higher-level degree in clinical social work or a mental health related field and have a minimum of two years of experience working with African-American clients seeking mental health treatment. Participation in the study will entail a face-to-face interview that can last between 45 minutes to an hour. Participation in the study will provide participants the opportunity to explore and discuss ways to better meet the mental health needs of African Americans within the therapeutic setting as well as within the African-American community.

Would you please help me recruit possible participants for my study? Your help will be greatly appreciated. To refer personal or professional contacts that meet the prior-mentioned criteria please forward the attached email directly to them. Upon receiving contact from your potential participant, I will return contact personally via phone. Lastly, a formal letter of consent will also be provided once participants voluntarily consent to participate in the study.

Thank you once again for your time and for your help!

Rabi

Appendix C

Potential Participant Recruitment Email

Dear Potential Research Participant,

My name is Rabi Jamar and I am a second year Master's degree student at Smith College School for Social Work. As a part of my graduation requirement, the completion of a thesis is required. For my thesis I am conducting research on the stigma of mental illness within the African American community from the perspective of African American clinicians. More specially, my study seeks to examine African American clinicians' perception of the stigmas that exist within the African American regarding mental illness, whether those stigmas hinder its members from seeking mental health services, and if those stigmas then affect the therapeutic setting. Additional information will include environmental barriers that may hinder/deter African Americans from accessing mental health services. I am hoping that you will participate and help to inform my research.

To participate you must self-identify as an African American or Black clinician, reside within the Atlanta metropolitan area, have a master's or higher-level degree in clinical social work or a mental health related field, and have a minimum of two years of experience working with African American clients seeking mental health treatment. Participation in the study will include a face-to-face interview that will last about 45 minutes to an hour. Furthermore, participation in the study will contribute to research intended to highlight the internal and external barriers that hinder African Americans from seeking mental health services and what that means for African Americans once they seek therapeutic services. Confidentiality will be protected through the use of a coding system and deletion of all names that may surface during the interview.

If you would like to participate in this study, have any questions, or would like more information about the study, please contact me via email or phone.

Thank you in advance for your time and consideration.

Rabi Jamar

Master's Candidate '13

Smith College School for Social Work

Appendix D

Informed Consent

Dear Prospective Participant,

My name is Rabi Jamar and I am a 2nd year Master's degree social work student at Smith College School for Social Work in Northampton, Massachusetts. I am conducting a study that explores the stigma of mental illness within the African American community from the perspective of African American clinicians. More specially, this study seeks to examine African American clinicians' perception of the stigmas that exist within the African American regarding mental illness, whether those stigmas hinder its members from seeking mental health services, and if those stigmas then affect the therapeutic setting. Additional information will include environmental barriers that hinder/deter African-Americans from accessing mental health services. The data collected will be used for my master's thesis, and subsequently may be used for future professional presentations and or publications.

I have asked you to participate in this study because you have self-identified as an African American or Black clinician residing within the Atlanta metropolitan area that has a master's or higher-level degree in clinical social work or a mental health related field, and who has a minimum of two years of experience working with African American clients seeking mental health treatment. By being a participant in this study I would like the opportunity to talk with you face-to-face for about 45-60 minute. Our conversation will be audiotape recorded and, once complete, I will transcribe, analyze, and code your tape. During our conversation, I will invite you to discuss your experiences, approach to, and thoughts related to race, stigma, and mental illness in the African American community. I also will ask you to respond to several demographic questions.

A possible risk to participating in the study is that you may experience temporary emotional discomfort with some of the interview questions that ask about the perceptions of stigma regarding mental illness in the African American community, and questions that ask you to self-reflect and discuss messages received about mental health within your own personal history. Your participation will enable you to confidentially share and reflect upon your own personal history and the messages you received regarding mental illness, and how those messages in turn shape the work you do with your clients. Another potential benefit for participating in the study will be the opportunity to contribute to research intended to highlight the internal and external barriers that hinder African Americans from seeking mental health services.

In order to protect your confidentiality, your transcription tape will be assigned a numeric code, all your identifying information will be removed, and your signed informed consent will be kept separately from your transcription tape. In discussing case material, I do ask that you refrain from using the names of clients or other identifying information in order to protect the confidentiality of your clients. My thesis advisor will also have access to the transcribed interview data, but only after all identifying information has been removed. In future presentations and publications I will use the coding system I created to ensure that your information is kept confidential and non-identifying. Furthermore, all of your electronically transcribed materials will be kept secure via use of password protection. Your informed consent and audio tapes will be securely locked and kept in a safe location for three years as required by Federal regulations. After that time, those materials will continue to be secured until they are no longer needed and then will be destroyed.

Your participation in the interview is completely voluntary and you have the right to refuse to answer any individual questions during the course of the interview. You also are free to withdraw from the study, but I ask that you inform me of your decision to withdraw both verbally and in written form within 48 hours of the interview's close, at which time transcription is scheduled to begin. Once I'm informed of your decision to withdraw, all your materials will be destroyed. If you have any questions about your rights or about any aspect of the study, please contact me via email or via phone. You also may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPAION, AND YOUR RIGHTS AND THAT YOU VOLUNTARILY AGREE TO PARTICIPATE IN THE STUDY.

Signature of participant _____ Date _____

I am providing a second copy of this consent form for your own records.

Appendix E

Demographic Questions

Please check the response that most accurately describes you, the CLINICIAN.

1) What is your age?

_____

2) How do you identify with in terms of gender?

_____

3) Please state your discipline and credentials on the line below.

_____

4) In what type of mental health setting do you primarily work (e.g. outpatient clinic, residential program, etc.)?

_____

5) How long have you worked in the mental health services field?

_____

6) How long have you provided therapeutic services specifically to African Americans seeking mental health treatment?

_____

7) In your current caseload, what percentage of your clients do you identify as being African American or Black?

_____

Appendix F

Guided Interview Questions

1. Reflecting upon your own personal history, what messages have you personally received about mental illness from your family? From your community? From religious organizations?

2. What do you observe/perceive are the attitudes of African Americans towards mental illness? Do you perceive that a change in these attitudes has occurred over the past 5-10 years? If so, please explain.

3. What do you identify as the stigmas associated with mental illness in the African American community? Feel free to provide case illustrations.

4. What is your perception of what inhibits African Americans from seeking mental health services?

5. What factors do you perceive influences African-Americans in their decision to seek mental health services? Feel free to provide case illustrations.

6. What do you believe needs to happen within the therapeutic setting to improve African Americans' comfort with disclosure? Feel free to provide case illustrations.