BLACK AMERICAN CLIENT PERCEPTIONS OF THE TREATMENT PROCESS IN A UNIVERSITY MARRIAGE AND FAMILY THERAPY CLINIC

By

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STRENGTH TO OVERCOME: BLACK AMERICAN CLIENT PERCEPTIONS OF THE TREATMENT PROCESS IN A UNIVERSITY MARRIAGE AND FAMILY THERAPY CLINIC

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(ABSTRACT)

Despite negative perceptions of therapy, Black Americans are seeking therapy. I interviewed 8 Black clients about their experience of MFT. I used the Multidimensional Inventory of Black Identity (MIBI; Sellers, Rowley, Chavous, Shelton, & Smith, 1997) to assess their racial identity.

Most participants thought it was strange for Blacks to seek therapy. Yet, these participants found the strength to seek therapy to protect their family and individual well-being. Participants found support from family, friends, and/or the church/religious beliefs. All attended church but few sought their pastor for therapeutic support.

The participants who initially preferred a Black therapist also strongly viewed race as central to their self-identity. However, participants expressed greater concern for therapist competence, skills, and warmth than for therapist race. Yet, many discussed the benefits of having a Black therapist, which were greater comfort, ease, and openness for Black clients in therapy, as well as greater cultural familiarity for Black therapists. All of the participants reported satisfaction with their therapist and generally reported a positive experience.

I also measured the experience of the first and third therapy sessions for Black and White clients, using the Session Evaluation Questionnaire (SEQ; Stiles, 2000). Black clients reported significantly less depth in the first session than White clients, suggesting a unique experience of therapy for Black clients. Also, Black clients that remained in therapy reported less smoothness in the first session than those who terminated. There were no significant findings for the third session. Research and treatment implications from these findings are discussed.

DEDICATION

To my living grandfather, Johnny B. Wyatt

To my deceased grandparents, Tal and Willie Kitchen, and Leopald Wyatt

To the ancestors that came before me and paved a pathway for my achievements

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To my immediate family, or as we say in MFT, family of origin, thank you for *everything*……… I definitely could not have climbed this mountain without your support and your vision of my success.

To God, my Creator, thank you for directing my path, sustaining me, and giving me the strength and faith to embark upon and complete this journey.

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CHAPTER ONE: INTRODUCTION

Statement of the Problem

African Americans, also referred to as Black Americans, are one of the largest minority groups in the United States (U. S. Census Bureau, 2002). African Americans, as a group, share certain values with other ethnic/racial minorities (Boyd-Franklin, 1989). However, African Americans have a unique history of oppression and discrimination in this country. African Americans are the only ethnic/racial minority group in the United States that was brought to this country as slaves. This distinct historical background contributes to a different minority experience and kind of cultural identity in America for African Americans, also referred to as Black Americans.

A history of oppression and racism still impacts the lives of all African Americans in this country (Boyd-Franklin, 1989). Boyd-Franklin (1989) states that racism is still "insidious and pervasive." Racism still invades the social fabric of our society in subtle and covert ways (Boyd-Franklin, 1989; McGoldrick & Giordano, 1996). Despite this, according to McGoldrick & Giordano (1996), people prefer to discuss ethnicity rather than race. They point out to the field of marriage and family therapy the need to recognize and eliminate racism. Similarly, Erskine (2002) explains that culture is chosen as a topic of discussion, over race and racism, which inhibits the ability to address racism. Many clinicians tend to deny color differences in therapy and espouse the idea of "color blindness (Boyd-Franklin, 1989)." However, this marginalizes those who experience discrimination on account of race.

Based on this unique cultural history in this country, African American experiences in the mental health system are also unique. The combined cultural values of African Americans and a history of experienced oppression in American society and discrimination in the mental health system have contributed to a unique response to mental health care. Despite increased use of mental health services among minorities since the 1960s (O'Sullivan, 1989; cited in Neighbors, Bashshur, Price, Donavedian, Selig, & Shannon, 1992; Zhang & Snowden, 1999), African Americans continue to be underrepresented in the mental health system (Leong, 2001; Snowden, 1999) and barriers to seeking help continue to exist (Leong, 2001).

Research reports document that minorities underutilize mental health services, especially in the private sector (Neighbors, et al, 1992; Snowden, 1999; Surgeon General,

1999). There has been some speculation about the reasons for this finding. Researchers and clinicians have posited that a strong reliance upon traditional social supports (church, friends, and family), mistrust of a predominately White American mental health system, fear of the mental health paradigm/treatment, stigma, and a history of racism and discrimination from the mental health system have contributed to the observed low use of mental health services of minority groups (Boyd-Franklin, 1989; Kurilla, 1998; Hines & Boyd-Franklin, 1996; Neighbors, et al, 1992; Surgeon General, 1999). It has also been suggested that a lack of minority mental health professionals has influenced the underuse of mental health services (Neighbors, et al, 1992; Thompson, Worthington, & Atkinson, 1994; cited in Okonji, Ososkie, & Pulos, 1996).

In addition, researchers and clinicians have observed that minorities tend to prematurely terminate treatment more often that their White counterparts (Kurilla, 1998; Neighbors, et al, 1992, Bischoff & Sprenkle, 1993). There have been several explanations for this observation. Some research has shown that socioeconomic status is related to this phenomenon and a large number of minorities are represented in the lower socioeconomic status. Thus, minorities have a higher risk of drop out (Neighbors, et al, 1992). Others have postulated that racial/ethnic differences in the therapeutic relationship influence this outcome. In addition, bias in diagnosis and treatment has been identified as a possible factor in the higher drop out rate among minority groups, particularly African Americans (Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2001).

Some research in the marriage and family therapy field has also demonstrated that African American clients drop out of therapy more often than White clients (Bischoff & Sprenkle, 1993). However, the results of a few representative studies on African American dropout have been mixed. These inconsistencies suggest that more research is needed to determine the factors involved in what keeps African American minority clients in therapy and what influences their decisions to prematurely terminate. Until now, much of the research in this area has been largely dialectical (using logic and intellectual discussion), studied demographic characteristics that have little clinical value, used data derived from existing case records, and was largely retrospective.

There has been a call for more open-ended questions and question flexibility in order to highlight descriptive-rich experiences of African American families in therapy

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with a European American therapist (Gregory & Leslie, 1996; Murphy & Faulkner, 1999). The voice of African American clients is a necessary part of gaining more knowledge about how to better serve them in treatment. A qualitative investigation can provide insight for the researchers and clinicians who do not clearly understand the experience of African American clients in marriage and family therapy. It has been suggested that as increased attention is given to racial/ethnic minorities in the field and that myths, unsubstantiated theories and generalizations concerning racial/ethnic minorities will be replaced with empirical data, qualitative and quantitative (Bean & Crane, 1996; Leslie, 1995).

In the field of marriage and family therapy, it has been asserted that there are many generalizations about African American families (Leslie, 1995) and most of the literature concerning African Americans in the marriage and family therapy field is largely theoretical (Bean & Crane, 1996). There continues to be a need for research-based knowledge to inform the field about how to best serve the African American minority population. Without empirically-based literature on African American and other minorities, the marriage and family therapy field cannot answer the call for more racially and ethnically relevant service (McGoldrick & Giordano, 1996; Surgeon General, 1999).

Furthermore, the apparent underutilization of mental health services and demonstrated drop out rates of African Americans inform us that further inquiry is needed regarding the experience of therapy for African Americans including the experience that promotes continued participation or premature termination of therapeutic treatment. There continues to be a need for more knowledge in this area so that marriage and family therapists can make informed decisions for treatment and form therapeutic relationships that recognize the intergroup and intragroup similarities and differences of racial and ethnic minorities without relying on myths, generalizations, and empirically uninformed postulations (Bean & Crane, 1996; Leslie, 1995). Some authors suggest improved training in these areas (Leslie, 1995; McGoldrick & Giordano, 1996). However, in order to train marriage and family therapists appropriately, there needs to be an expanded depository of credible, researched-based knowledge regarding family therapy with racial/ethnic minorities.

Rationale of the Study

The African American experience of marriage and family therapy needs thorough investigation. Despite inconsistency in research results, most studies show that there is a significant difference between African American and European American drop out rate (Bischoff & Sprenkle, 1993). Researchers also indicate that African Americans are underrepresented in the mental health system (Leong, 2001; Snowden, 1999) Yet, there is a dearth of valuable investigations concerning the African American experience of marriage and family therapy in order to better understand their perception of the treatment process, such as obstacles to the initiation of therapy, the experience of the therapeutic process, the perception of the therapist, and the reasons for continued participation or premature termination. This information would provide more informed guidance for therapists who work with African American families.

In this thesis, I attempted to fill this gap on African American experience in therapy. I investigated the African American experience in marriage and family therapy through a qualitative study, involving interviews with African American family members who participated in marriage and family therapy. Qualitative methods allowed participants to discuss their marriage and family therapy experience and identify possible cultural factors unique to their experience as African American. This is consistent with the request for more empirical studies, especially qualitative approaches that allow for more open-ended questions and flexible questions to generate description-rich experiences of the therapeutic process (Leslie, 1995; Gregory & Leslie, 1996; Murphy & Faulkner, 1999).

Some African Americans may choose to use more traditional forms of help, such as relatives, friends, and ministers in the church (Boyd-Franklin, 1989; Fischer & Shaw, 1999; Franklin, 1993; Neighbors, et al, 1992; Wilson & Stith, 1991). It is hypothesized that these informal support networks in the community may act as substitutes for mental health treatment (Snowden, 1998). Still, others may choose to seek external support networks. In order to help understand this issue, the interviews addressed the African American clients' efforts to resolve the presenting problem before initiating therapy and their perceived impetus for the initiation of therapy.

Writers have also identified that African Americans do not seek therapy due to the stigma or negative attitude toward receiving mental health treatment (Leong, 2001;

Neighbors, et al, 1992; Surgeon General, 1999). They have elaborated that African Americans may fear the reaction the African American community may have about using traditional forms of therapy (Boyd-Franklin, 1989; Hines & Boyd-Franklin, 1996). There may be concern for being labeled as "crazy" by the community for seeking therapy and concern for the responses of family members. This study investigated these postulations by incorporating questions concerning these thoughts in the interview questions. For example, participants were asked about the reactions of significant others to their decision to seek therapy.

Researchers also point to mistrust of a White American therapist and/or a mental health system that is perceived to be a White, middle-class institution (Boyd-Franklin, 1989; Diala, et al, 2001; Leong, 2001; Surgeon General, 1999). A history of racism and discrimination in the United States continues to influence the daily lives of African Americans. Continued discrimination is found to be subtler, and is oftentimes referred too as invisible (Boyd-Franklin, 1989; McGoldrick & Giordano, 1996; Surgeon General, 1999; Erskine, 2002). Although racial tensions have eased since the Civil Rights Movement in the 1960s, there continues to be speculation that stereotypes and/or racism influences the perception of therapeutic treatment. This concern is, however, supported by evidence of bias in diagnosis and treatment of African American psychopathology (Diala, et al, 2001; Surgeon General, 1999; Zhang & Snowden, 1999). Based on past experiences in the health system, in general, African Americans fear misdiagnosis, "prescription of medication for behavioral and population control," (p.78) and the abuse of clinical records by the government system (Hines & Boyd, 1996). Thus, it was important to use questions in this qualitative study that evaluated the experience of the environment and allowed for the exploration of racism and discrimination.

Although African American families seem to be resistant to the idea of therapeutic treatment, they are seeking help from the mental health system (Hines & Boyd-Franklin, 1996; Leong, 2001; Snowden, 1998). Unfortunately, some research demonstrates that after the initiation of treatment African Americans tend to have a high drop out rate (Bishoff & Sprenkle, 1993). Thus, it has been speculated that the therapeutic relationship influences African American drop out. It has been evidenced that, as much as 30% of the variance in psychotherapy outcome is related to variables in the therapeutic relationship. Relationship factors, such as therapist acceptance, non-

possessive warmth, positive regard, affirmation, and self-disclosure, have been reported by clients in therapy to be important to their therapeutic success (Miller, Duncan, & Hubble, 1997). Boyd-Franklin (1989) has also pointed out that joining, establishing a human connection, and certain characteristics, such as race, are important factors in a therapist-client relationship with African Americans.

The research that has attempted to examine factors in the therapist-client relationship has had inconsistent findings (Bischoff & Sprenkle, 1993). Researchers have examined variables such as racial differences in therapeutic dyads and satisfaction of therapy (Gregory and Leslie, 1996; Murphy & Faulkner, 1999; Neimeyer & Gonzales, 1983; Vera, Speight, Mildner, & Carlson, 1999; Warren, Jackson, Nugaris, & Farley, 1973). This thesis will address these issues by discussing with the research participants their experience of the therapeutic relationship and examining the participants' evaluation of the first session of therapy.

Although not consistent, studies suggest that therapeutic relationship factors determine successful therapeutic outcomes. It is indicated that therapist-client race differences, however, may not be the key factor influencing premature termination or unsuccessful therapeutic outcome. These studies imply that factors such as gender, agreeableness, education, roles in therapy, degree of empathy, and the smoothness and positivity in the first session may be more significant than race (Gregory & Leslie, 1996; Vera, Speight, Mildner, & Carlson, 1999). Specifically to African Americans, it has been suggested that socioeconomic status should be assessed along with race (Boyd-Franklin, 1989; Neighbors, et al, 1992; Leong, 2001; Snowden, 1999) as influential factors in African American utilization and drop out. Thus, this study will also describe the socioeconomic status of the research participants to help elaborate on the impact of race on socioeconomic status on continuing participation in therapy. As McGoldrick and Giordano (1996) point out, ethnicity interacts with economics, race, and class.

Theoretical Framework

This study will be conducted under the frameworks of critical race theory and the multidimensional model of racial identity, a conceptualization of African American racial identity. In the next section, both of these theories will be described.

Critical Race Theory

Critical Race Theory asserts that racism is a normal, every day occurrence in the lives of many people of color and asserts that change will not come with the color-blind perception or "formal" ideas of equality (Delgado & Stefancic, 2001)." It is suggested that these conceptions will only eliminate the most severe, blatant forms of racism in our society. The critical race theorists, such as Derrick Bell, Kimberle Crenshaw, and Angela Harris, believe that racism continues to exist in the U.S. because there are material and psychic benefits to such thoughts and behavior. Thus, it is assumed that racism is challenging to remove from the fabric of society. This is a major tenet of the theory called "interest convergence." These underlying ideas of the critical race theory reinforce the significance and importance of looking at race in marriage and family therapy. It also establishes the importance of changing racism in America, by starting with institutions such as the mental health system. I used this theory to allow for the exploration of issues specific to the experience of African Americans as racial and ethnic minorities in the development of this study, particularly in the questions addressed, the participants selected, and data analysis.

Critical race theorists have also espoused the idea that race is socially constructed (Delgado & Stefancic, 2001). In other words, the categories of race were created by society to manipulate the racial categories to its own advantage. They supplement this point with the recent findings in biology and genetics that there is no basis for race biologically or genetically. They explain that there are groups of people that share origins and have similar physical traits such as color of skin, build, and hair texture. However, these characteristics are not related to the characteristics that all humans share, which are intelligence, personality, and moral behavior. As McGoldrick & Giordano (1996) stated, "Race is an issue of political oppression, not a cultural or genetic matter" (p.14). Thus, it becomes important not to marginalize race, by considering its impact in marriage and family therapy research.

Anti-essentialism and intersectionality are also important ideas of this theory (Delgado & Stefancic, 2001). These ideas propose that, "race has its own origins and ever evolving history" (p.8). Thus, race is not the single determinant of a person's identity. In addition to a racial identity, individuals have identities based on gender, occupation, religion, socioeconomic status, etc. This further indicates that people may

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have different identities that may conflict with the other and demand differential allegiance and loyalty. This study will examine race, as well as other variables such as socioeconomic status to postulate how salient the African American identity may be in the experience of the therapeutic process. Thus, these notions provide a framework for evaluating the role racial identity plays in African American experience of the mental health system, a predominately White American institution. In addition to the ideas of critical race theory in regards to identity, the Multidimensional Model of Racial Identity will be used in the study to further understand the experience of African Americans in marriage and family therapy.

The Multidimensional Model of Racial Identity (MMRI)

The MMRI defines racial identity in African Americans as "the significance and qualitative meaning that individuals attribute to their membership within the Black racial group within their self-concepts" (Sellers, Smith, Shelton, Rowley, & Chavous, 1998; p.23). Thus, they ask the questions: "How important is race in the individual's perception of self?" and "What does it mean to be a member of this racial group?" To answer these questions, there are four underlying assumptions. First, they assume that identities are situationally different, as well as stable. Second, they assume that people have several identities that are hierarchically ordered. Third, they believe that people are the best judge of their own racial identity. Fourth, MMRI developers are more interested in the status of a person's racial identity, rather than examining the development of their racial identity. Although the theory recognizes the influence of society on the development of the self, it clarifies their interest in the individual's view of his or her identity, borrowing the phenomenological approach to studying racial identity.

This study incorporates the Multidimensional Inventory of Black Identity (MIBI) (Sellers, Rowley, Chavous, Shelton, & Smith, 1997) as a tool to analyze the racial identity of the African American interviewees. This helps to determine if there are differences in racial identity that may account for different perceptions of race as a factor in marriage and family therapy. As it has been stated, people have more than one identity, and the MIBI will allow me to consider to what degree might race be a factor in the African American experience of marriage and family therapy. The MIBI allows the researcher to examine the salience of race, since race may be more important in different situations. It has already been speculated that variability in the African American racial

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identity is based on geographic location, education, level of acculturation, and other variables (Boyd-Franklin, 1989). Thus, I examined the impact of socioeconomic differences along with racial identity.

During the course of the study, it is imperative to be mindful that the researcher is not absent of beliefs and values. This study attempts to induct the participant's view of the world and understand their reality, yet its interpretation will not be untouched by the worldview of the researcher, who is also African American. Critical race theory posits that there is a "unique voice of color" that is bound by a similar history of discrimination and oppression that the dominant society does not share. Thus, a common status as an American minority "brings with it a presumed competence to speak about race and racism" (p.9). The beliefs, values, and the presumed competence on race and racism of the researcher directly affected which questions were chosen and examined. The process of self-reflexivity is very important in this study. It involved the researcher actively, continuously, and explicitly addressing any biases or assumptions while delving into data collection and analysis. Through discussion of the data, I used the perspectives of the thesis committee chair and a thesis committee member to curtail any biases or assumptions of the researcher.

Researcher

I am a female, African American graduate student, preparing to receive a Master's degree in marriage and family therapy. I have more than three years of experience working in the mental health field. I have observed the small number of African American families utilizing the mental health field and have witnessed their wariness toward seeking or accepting mental health assistance, such as counseling services. I have observed African American families deny assistance despite the apparent need. Thus, I am interested in discovering why it is difficult for many African American families to effectively use the services of mental health professionals and remain after they have taken the steps in that direction.

As an African American from the South and raised in the city, I understand the apprehension associated with working with institutions of the majority culture, that are entrenched in the male, European American, and middle class values. Apparent from previous conversations with other African Americans, the fear is that people will judge

your character on the basis of negative stereotypes perpetuated by professional literature or the mass media. Some African Americans feel that they have to prove all the negative stereotypes to be wrong. The feeling is that European Americans and some minorities do not know many African Americans and will not be able to understand the African American experience and the concerns that come from the experience. It is hard for some African Americans (not all) to place themselves in a strange, majority or non-African American context, especially if they expect to be probed and examined. Many times, it is a humbling and isolating experience. Thus, those who make it through the door demonstrate their courage, strength, and hope. Considering this, I ask myself - what do therapists need to know about African American experience in therapy to serve them better? What brings them in to therapy? And why do many leave so soon after arrival?

These experiences and the conversations with other African Americans, aided by the literature review on African American utilization and drop out in marriage and family therapy has prompted this investigation. Despite the postulations and suggestions in the literature, there appears to be an absence of an important component of this research topic – the voices of the persons being studied. The best answers seem to reside within the worldview of the African American families.

Purpose of the Study

The purpose of this study is to explore the experiences of African Americans as clients at a marriage and family therapy university clinic. Researchers and clinicians remain divided on the interpretation of African American early termination (Sue, 1988) and there continues to be a lack of consensus on the reasons that minorities are underrepresented in the mental health system (Neighbors, et al, 1992). Some stress ethnicity training for therapists, increased awareness of therapist-self, and/or directly addressing issues of racism and discrimination in therapy (Franklin, 1993; McGoldrick & Giordano, 1996; Preli & Bernard, 1993; Wilson & Stith, 1991; Winek & Carlin-Finch, 1997). Others advocate for more African American marriage and family therapists (Sue, 1988; Wilson & Stith, 1993). The exploration of African American experiences in marriage and family therapy will add a piece to understanding African American utilization of treatment and will give insights into reasons for continued and discontinued treatment.

This qualitative study will allow the voices of African American clients to be available in the marriage and family therapy literature for researchers and clinicians to inform their work with this minority group. Mental health professionals are being challenged to provide treatment that is more responsive to ethnic and racial minorities (Kurilla, 1998; McGoldrick & Giordano, 1996; Surgeon General, 1999). However, marriage and family therapy research needs to focus on increasing understanding of racial and ethnic minorities and their experience in therapy (Leslie, 1995). Clinicians need knowledge of how to increase African American utilization of mental health services, how to improve credibility of marriage and family therapy to the African American population, and how to work with this population more effectively based on the available empirical research, quantitative and qualitative. This study can inform clinicians of the experience of some African American clients in the initiation process, the therapeutic process - aspects of therapy that hinder or facilitate African American their retention in family therapy, and reasons for continued or discontinued treatment. The study establishes empirical data that begins to fill the gap on ethnic and racial minorities and benefits clinicians by providing information to aid their clinical decisions when working with African American families.

Research Questions

This study will qualitatively examine the experience of African Americans as clients at a university marriage and family therapy clinic. Its aim is to understand their experience initiating therapy, their experience of the therapy environment, their experience in therapy, and their reasons for continuation or discontinuation of therapy. The research questions that will be studied are:

1)   What are the thoughts and feelings of African American clients during the initiation process of therapy?

This question and the sub-questions address the postulations that African Americans underutilize mental health services due to negative attitudes toward mental health, mistrust, stigma, and their tendency to rely on family and religious support (Boyd-Franklin, 1989; Hines & Boyd-Franklin, 1996; Kurilla, 1998; Neighbors, et al, 1992;

Surgeon General, 1999). It allowed exploration of what prompted their utilization of marriage and family therapy, if they were hesitant about seeking therapy, and how they tried to resolve the presenting issues before entering treatment.

2) How did the university/research-oriented environment of the building, waiting room, and the therapy room affect the thoughts and feelings of the African American clients?

Literature explains that African American minorities may not feel comfortable seeking treatment because therapy is considered to be a White American, middle class institution (Surgeon General, 1999). Also, African Americans have been victims of the inappropriate use of the overall health system in this country's past; thus, African Americans may be avoidant of health institutions (Hines & Boyd-Franklin, 1996).

3) What were the thoughts and feelings of African American clients during therapy sessions?

Research demonstrates that African American clients may drop out of therapy for reasons such as: racial differences, lack of understanding, and indirect intervention strategies (Franklin, 1993; Okonji, et al., 1996). Researchers also indicate that race is not an important factor predicting dropout as much as socioeconomic status, approach, gender, agreement, degree of empathy, education, and roles in therapy (Bischoff & Sprenkle, 1993; Okonji, et al., 1996; Vera, Speight, Mildner, & Carlson, 1999). This question allowed the exploration of the clients' perceptions of the treatment and how race influenced the experience, whether there was a same-race therapist or not.

4) Why do African American clients continue or discontinue therapeutic services?

Many factors in the therapeutic process may play a role in influencing a client's decision to continue or discontinue treatment. This question allowed the researcher to explore what reasons, therapeutic or extratherapeutic, influence the African American client's decision to continue or discontinue therapy.

CHAPTER TWO: LITERATURE REVIEW

Introduction

In this review of literature, I discuss the uniqueness of the African American population as a racial/ethnic minority group. Then, I discuss the observed underutilization of mental health services by African Americans and its significance for this population in regard to the perceived need of services. Lastly, I discuss the patterns of African American utilization and variables that influence continuation or discontinuation of services.

African Americans as a Racial/Ethnic Minority

African American Reference Labels

This paper uses the label, African American, to refer to all people of African descent, who are also referred to as Blacks or Afro-Americans in the literature reviewed. The term, Black, usually includes people of color from the Caribbean and Latin America (Goldberg, 1993). The term, African American, usually does not include these people of color. As Hill (1993), points out, there are 14 subcultures among Blacks in the United States, including those that are Afro-English, Afro-Spanish, and Afro-French. Although the concern of this thesis is with persons of African decent and with a history of slavery in the United States, the literature review discussed African Americans without distinction of whether or not the group included those of African descent with or without a history of slavery in the United States. However, much of the literature also uses the terms African American, Afro-American, and Blacks interchangeably. Thus, this literature review will use the term African American as an overarching category for the reference of African Americans, Afro-Americans, or Blacks in the literature reviewed.

African Americans are considered an ethnic minority (Ho, 1987; McGoldrick, Giordano, & Pearce, 1996). McGoldrick, et al. (1996) states that "the concept of a group's 'peoplehood' is based on a combination of race, religion, and cultural history and is retained, whether or not members realize their commonalities with one another" (p.1). Ethnicity connotes a "common ancestry through which individuals have evolved shared values and customs." It is also implies cultural uniqueness (Ho, 1987). African Americans share a common African ancestry and legacy of slavery in America, from which values and customs have evolved.

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African American people are also viewed as a cultural group (Surgeon General, 1999). Culture refers to a shared heritage, beliefs, norms, and value system. There have been several African American cultural values that have been identified (Ho, 1987). These include: strong kinship bonds, strong education and work achievement orientation, flexibility in family roles, commitment to religious values and church participation, humanistic orientation, and endurance of suffering.

Simultaneously with being a unique cultural and ethnic group, African Americans are minorities in America. The term "minority" denotes a group of people who view themselves as economically and politically relatively powerless, with a history of unfair and discriminatory treatment (Ho, 1987). As with other minority groups, African Americans continue to struggle against discrimination in America.

Although African Americans constitute a distinct ethnic minority group in America, they also have a common racial distinction. Race is an important characteristic in the African American experience in America (Boyd-Franklin, 1989). Race refers to similarities in physical characteristics, such as skin color, hair texture, appearance, and implies a shared heritage and origin (Boyd-Franklin, 1993). However, it is a socially contrived category that assumes group homogeneity (Celious & Oyserman, 2001) and carries meaning in regard to status and privilege (Delgado & Stefancic, 2001). It is believed to serve the purpose of lumping a group of people into the same social status regardless of socioeconomic status to allow for the political oppression of the defined group (McGoldrick, et al, 1996). Thus, it is also imperative that African Americans are explored as a racial group, as well as an ethnic group to prevent the marginalization of the experience of race in America (Hardy & Laszloffy, 1994; cited in Leslie, 1995).

African Americans are a racial/ethnic minority group in America with a distinct culture (Boyd-Franklin, 1989). Thus, African Americans are discussed as racial minorities, ethnic minorities, and as a cultural group. Much of the literature has addressed African Americans under these terms. Thus, these concepts are discussed in this thesis in reference to African American people.

Much of the literature that discusses African Americans as a group, treated African Americans and African American families as a homogenous group. However, the entity referred to as *the* Black family does not exist (Allen, 1995; Boyd-Franklin, 1989). Treating African Americans as a homogeneous entity has functioned as a vehicle

to distinguish African Americans from other racial/ethnic groups. However, African Americans are diverse in values, characteristics and lifestyles based on gender, age, skin tone, socioeconomic status, regional background, education, religious background, and level of acculturation (Allen, 1995; Boyd-Franklin, 1989; Celious & Oyserman, 2001). Unfortunately, making blanket statements about *the* Black family has been unproductive, resulting in an inaccurate view of the African American population (Boyd-Franklin, 1989).

Generalizations about African American people produce stereotypes (Allen, 1995). Stereotypes serve the purpose of reducing large and complicated information to manageable smaller categories; however, truth and the intricacies of African American family life are lost in blanket statements about African Americans. These stereotypes promote images of African American life that are perpetuated in the media, academia, and politics, which have negative consequences for all African Americans (Celious & Oyserman, 2001). These consequences differ based on characteristics such as socioeconomic status, gender, and skin tone of the individual African American.

Many of the generalizations about African Americans are referenced against White Americans, with White Americans representing the norm (Willie, 1988). Research literature abounds with Black-White dichotomies (Allen, 1995; Celious & Oyserman, 2001). The tradition has been to describe African American behavior and lifestyle against White Americans, as the ideal (Willie, 1988). Thus, there is a call for research to show the heterogeneity of the African American population in America (Allen, 1995; Celious & Oyserman, 2001; Willie, 1988). This heterogeneous view of African Americans should also be considered in the collection and interpretation of results in the research of African American mental health service use.

Researchers also suggest that race and class are not separated in evaluation of minorities (Boyd-Franklin, 1989; Snowden, 1999). McGoldrick & Giordano (1996) suggest that ethnicity is closely tied to economics and class. Some believe that class is more predictable of people's behavior than ethnicity. This relationship of ethnicity and class is described as "ethclass" (McAdoo, 1993). Hence, it is proposed that the lives of minorities are examined by class and ethnicity status. There are distinct behavioral responses at the intersection of ethnicity and class (McAdoo, 1993). In addition, Boyd-

Franklin (1989) argues that class distinctions within African Americans are not parallel to society's distinction of class differences.

Some clinicians suggest that class is more important than race (Hill, 1993). However, some clinicians and researchers also challenge the "class not race" myth (Boyd-Franklin, 1989). They explain that this idea promotes an "illusion of color blindness." Color blindness is the belief that a person should treat all persons the same regardless of race (Delgado & Stefancic, 2001). Boyd-Franklin (1989) suggests that it ignores racial and cultural differences. Some therapists may fear that seeing the color of a client's skin as synonymous with discrimination (Hardy & Laszloffy, 1998). However, Delgado and Stefancic (2001) contend that the perception hinders the eradication of racism in American society because the discriminatory experiences based on race become marginalized. There are African American clients that have been raised in an all-White atmosphere that may advocate being "color blind" (Boyd-Franklin, 1989). However, despite differing perceptions of race in the African American community, race continues to influence African American advancement (Hill, 1993) and it is related to African American psychological well being (Boyd-Franklin, 1989).

Racial Identity

Differing perceptions of race in the African American community is related to racial identity. Racial identity refers to the extent to which race influences a person's self-concept and consequent behavior (Rowley, Sellers, Chavous, & Smith, 1998). In the African American population, racial identity is heterogeneous (Celious & Oyserman, 2001). It is affected by socioeconomic status and situational context. Rowley, et al. (1998) explains that all African Americans are able to articulate their feelings about being African American due to the significance placed on race in America. However, individuals differ on the degree to which those feelings influence the self-concept and are based on the meaning that they give to race.

Models of racial identity have been developed to conceptualize healthy racial identity (Sellers, et al., 1998). However, there have been different opinions of what constitutes healthy racial identity development for African Americans. In the beginning, researchers viewed African American racial identity within the context of oppression in America, without consideration of the influence of African American culture in the daily lives of African American people. The conceptualization of racial identity in these terms

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is called the mainstream approach. The mainstream approach focuses on a universal process of ethnic identity development and the significance of this to individuals. It also views African American racial identity as involving a damaged self-concept as a result of stigma in America.

Another group of researchers later began to espouse a new conceptualization of racial identity that incorporated the influence of African American culture on African American racial identity. This group's collections of theories are called the underground approach. The underground approach examines the unique experience of African Americans in the context of culture and oppression. It also acknowledges the effect of stigma on the self-identity on African Americans but, in addition, it recognizes the positive impact of African American culture on ego development. Some researchers in the underground approach conceptualize African American racial identity as a continuum, with the values of the dominant society on the opposite end of African American cultural values. They suggested that healthy African American identity would lie on the end of the continuum that is closer to African American values, referring to a preference for own-group values. While others, such as Cross's Nigrescence model, conceptualizes healthy identity development as five stages that culminate in the ability to view the positives and negatives of the Black race and the White race.

However, Sellers, et al. (1998) has integrated components of both the mainstream approach and the underground approach to African American racial identity. It is called the Multidimensional Model of Racial Identity (MMRI). According to these theorists, racial identity in African Americans is the "significance and qualitative meaning that individuals attribute to their membership within the Black racial group within their self-concept" (p.23). The theory does not determine if an individual's racial identity is healthy or unhealthy, nor does it judge it as right or wrong. It is based on four assumptions and specifies four dimensions that are important in the examination of racial identity.

The first assumption is that identities are stable and situational dependent components of an individual (Sellers, et al., 1998). The self-concept is influenced by contextual cues and allows the stable components of the identity to influence the behavior at the specific event. The significance and qualitative meaning given to race by the individual represent the stable components of the identity. However, these stable

components can gradually change over an individual's lifetime, as the individual remains affected by social and developmental forces.

The second assumption is that individuals have many identities that are hierarchically ordered by the individual (Sellers, et al., 1998). The MMRI is concerned with how important race is to the individual's self-identity. This assumption allows the MMRI to explore race within the context of other significant identities of an individual. The relative significance of other identities has implications for the significance of racial identity, as an African American.

The third assumption says that an individual's view of their own racial identity is the best and most valid indicator of their identity (Sellers, et al., 1998). The MMRI recognizes that society influences the development of self but chooses to focus on the individual's perception of their racial identity. It takes a phenomenological approach to racial identity. Although the focus is on the self-perception of racial identity, they also expect that behavior of the individual will be reflective of the racial identity characteristics perceived. However, the MMRI recognizes that contextual factors influence the relevance of race, thus behavior in a specific context may be more closely related to another salient identity.

The fourth assumption states that the MMRI is primarily concerned with the status of a person's racial identity rather than the development (Sellers, et al., 1998). The MMRI chooses to emphasize the significance and nature of a person's racial identity at a specific moment of time. It does not place individuals within a stage of development. It, however, acknowledges that a person's perception of their racial identity will change over the lifetime.

The first dimension of the MMRI is called racial salience (Sellers, et al., 1998). It refers to the "extent to which one's race is a relevant part of one's self-concept at a particular moment or in a particular situation" (p.24). Salience examines the situation and the associated situational cues, and is related to the degree of significance given to race by the individual. Differences in individual racial salience become more apparent within ambiguous situations and are determined by the stable properties of race in the individual's self-concept (Centrality). Racial salience, thus, is a mediator between the stable properties of racial identity and the behavior chosen within a given situation.

The second dimension is called racial centrality (Sellers, et al., 1998). It refers to the "extent to which a person normatively defines himself or herself with regard to race "(p. 25). It is considered to be a relatively stable dimension with different contexts. The unit if analysis is the perception of racial identity that remains more constant across different situations. Racial centrality also implies that individuals have identities that are hierarchically ordered.

The third dimension to be discussed is called racial regard (Sellers, et al., 1998). It refers to a "person's affective and evaluative judgment of her or his race in terms of positive-negative valence" (p. 26). It addresses how positively or negatively an individual views their race. Regard has two components, private regard and public regard. Private regard is specifically relates to how negatively or positively one feels toward African Americans and being African American. Public regard is concerned with the extent that the individual believes others outside the African American race view African Americans positively or negatively.

The fourth dimension is called racial ideology (Sellers, et al., 1998). It deals with the individual's beliefs, opinions, and attitudes about how African Americans should behave. Racial ideology addresses the individual's perception of how African Americans should live and interact with the broader society. Four proscribed ideologies, nationalist ideology, oppressed minority ideology, assimilation ideology, and humanist ideology, have been suggested as representative of the beliefs of African Americans in respect to believed standards of African American behavior.

The nationalist ideology suggests that being Black is a unique experience (Sellers, et al., 1998). Those who espouse a nationalist ideology assert that African Americans should be in control of the group's destiny, without regard to the opinions of other groups. They have an increased propensity to socialize within predominately African American contexts and be active in African American organizations. Nationalists may also view African American status as being marginalized and have a greater appreciation for the uniqueness of African American culture.

The oppressed minority ideology is concerned with the marginalization of African Americans (Sellers, et al., 1998). However, it is also concerned with the marginalization and oppression of other groups. Those who espouse oppressed minority beliefs are more likely to support social strategies of change that involve the cooperation of other groups.

Oppressed minority ideologists are also more likely to focus on the forces of oppression in general.

The assimilationist ideology is concerned with the notion of African Americans as having similarities with the American society (Sellers, et al., 1998). A person that espouses this ideology identifies more with being American and is interested in associating more with mainstream America. Those with assimilationist beliefs do not ignore racism nor do they lack identification with African American culture. However, they support that social change will be achieved through working with the system established and interacting with White Americans.

The humanist ideology focuses on the common characteristics of people as humans (Sellers, et al., 1998). Those who espouse this ideology do not view people in terms of race, gender, class and other sociodemographic characteristics. They prefer to focus on qualities within an individual. They may view oppression as a problem, but not specifically for African Americans. They view it in terms as a problem of the human race.

The influence that racial identity has on behavior in situational contexts is determined by the interaction of the four dimensions discussed above (Sellers, et al., 1998). A person's ideology and regard is representative of the meaning placed on being African American. Salience and centrality determine the accessibility of the constructs, ideology and regard. Dependent on the situational cues, race may be come more accessible or salient in any given situation. At the same time, race may become more accessible in a given situation depending on the person's proclivity toward race being a salient factor (centrality or chronic accessibility). Thus, both racial salience (situational cues) and racial centrality (personal proclivity) interact to determine the accessibility in a given situation.

Sellers, et al. (1998) has operationalized the Multidimensional Model of Racial Identity with the development of the Multidimensional Inventory of Black Identity (MIBI). Research using the MIBI has demonstrated the significance of racial identity in areas such as African American social behavior and perceptions of racial discrimination. Sellers, et al. and Shelton and Sellers (1997: cited in Rowley, et al., 1998) found that higher racial centrality was associated with behaviors such as enrolling in Black Studies, having an African American best friend, and greater involvement in social circles with

African Americans. This study supports the assumption that racial identity, as operationalized by the MIBI, would be related to African American behavior and social activity. Shelton and Sellers (1996; cited in Rowley, et al., 1998) also found that racial identity, specifically racial centrality, was predictive of attributions made to race in racially ambiguous situations. As these studies show, the MIBI allows researchers to gain understanding of the commonalities and distinctions of how African American individuals experience race and racial discrimination in their daily lives.

African American Experience in America

Allen (1995) notes, "…while over time the terms of reference (e.g., Negro, Colored, Black, African American, Afrikan) have changed, the degraded cast status of Black people has been an immutable constant" (p.573). This is related to the racism and discrimination that African Americans have experienced in America.   According to the critical race theory, racism is a common occurrence in American society for persons of color (Delgado & Stefancic, 2001). It has also been defined as the social processes through which individuals or groups are identified by their race and used as the reason for discrimination (Erskine, 2002). It continues to influence the African American experience in America.

Racism and discrimination affect all African Americans and every aspect of their life. African Americans have experienced a long history of racism and discrimination in this country. It influences their behavior toward each other and toward non-African Americans. Hill (1993) describes different types of institutional discrimination. He makes a distinction between intentional institutional discrimination, overt and covert, and unintentional institutional discrimination. Intentional overt discrimination occurs when organizations and institutions use bias through racial or ethnic criteria. Intentional covert discrimination occurs with the use of non-racial criteria that are, however, strongly related to race. Unintentional discrimination are actions taken by organizations and institutions that are discriminatory although not purposely designed to be so, such as policies that have negative effects on racial and ethnic minority communities. An example of unintentional discrimination would be the increase in eligibility requirements for retirement. African Americans, especially African American men, have a shorter life span than White Americans. Thus, African Americans as a group continue to experience many forms of discrimination.

Racism and discrimination today is more subtle and invisible (Erskine, 2002). Thus, it may unknowingly pervade therapeutic encounters in marriage and family therapy. Racial stereotypes can have a negative impact on the therapeutic context when they are used to inform therapist perceptions (Priest, 1991). Some researchers and professionals suggest that therapists' lack of understanding of racism and discrimination are factors that influence African American utilization of mental health services. Anderson J. Franklin (1993) iterates that White American therapists tend to be insensitive to the discrimination African Americans experience and that they fail to understand them; thus, African American men terminate treatment due to the discontent with having to educate their therapists. He states that, for these reasons, they are skeptical of therapy.

Mental Health Services for Racial and Ethnic Minorities

The United States mental health system has recognized the need for improved mental health services for racial and ethnic minorities, which includes African Americans (Surgeon General, 1999). This recognition began in the 1960's, during the civil rights movement and the continuous influx of immigrants that the decade witnessed. In 1960, only 11.4% of the population was non-White. Since then, this percentage has doubled. Currently, 22.9% of the population is non-White. In other words, about one in every four Americans are racial or ethnic minorities as opposed to about one in ten being a minority in 1960. This increase in minority numbers generated concern for minority utilization of mental health services and initiated the evaluation of appropriate treatment for minority groups in the mental health field.

The African American population has also grown since the 1960's and has received increased attention. In 1960, African Americans constituted ten and a half percent (10.5%) of the American population (U.S. Census Bureau, 2002). Today, the African American community currently constitutes 12.9% of the U.S. Population (U. S. Census Bureau, 2002). It is projected that due to the immigration of Blacks from the Caribbean and other countries, the number of Blacks in this country will continue to grow (O'hare, Pollard, Mann, & Kent, 1991). Despite awareness of these trends, the minority population remains underserved and the system continues to be unprepared to provide appropriate services (Surgeon General, 1999).

Epidemiology

A greater proportion of the African American population has an increased risk of psychopathology than the White American population (Surgeon General, 1999). Persons of lower socioeconomic status are two and a half times more likely to have a mental health disorder. Minorities are three times as likely to live below the poverty line as are non-minorities. It is believed that an environment of stress increases psychopathology (Takeuchi & Uehara, 1996). Twenty-four percent of the African American population lives below the poverty line compared to eight percent (8%) of Whites (Snowden, 2001). This high representation below the poverty line increases African American risk for mental health disorders. However, there have been inconsistent findings concerning the prevalence of mental health disorders in the African American community.

Regier, Farmer, Rae, Myers, Kramer, Robins, George, Karno, and Locke (1993; cited in Surgeon General, 1999) reports that estimates show that African Americans have a higher prevalence of mental disorders than White Americans. Based on a review of literature, Snowden (2001) found that some researchers reported that a greater number of African Americans have panic disorders, sleep disorders, phobias, and somatization syndromes than White Americans. Yet, he also found that Kessler, et al. (1994; cited in Snowden, 2001), based on the National Comorbidity Survey, reported that African Americans have a lower lifetime prevalence of mental health disorders than White Americans and are less likely than White Americans to report comorbid substance abuse disorders. However, Snowden (2001) has found that research on the epidemiology of mental health disorders in African Americans has yielded mixed results. He postulates that, based on the reports of no differences in lifetime and current disorders found between African Americans and White Americans (Robins & Regier, 1991; cited in Snowden, 2001), to higher individual disorders of phobic disorders and somatization disorders among African Americans (Zhang & Snowden, 1999), to lower lifetime prevalence and lower substance abuse comorbidity among African Americans than White Americans (Kessler, et al., 1994; cited in Snowden, 2001), that the general consensus in the literature is that African American prevalence of mental disorders is not higher than White American prevalence of mental disorders.

Zhang & Snowden (1999) also reported that there was a smaller gap found between African Americans and White Americans and posited that either the number of

mental disorders increased in the African American population or White Americans are reporting less mental health problems. However, Snowden (2001) warns that African Americans are overrepresented in the mental hospitals, in the jails, and among the rural and inner city poor. He asserts that these high need populations are not considered in the household surveys and suggests that the prevalence may be higher with their inclusion in the surveys.

African American Underutilization

It is the goal of the American mental health system to improve utilization and ensure appropriate and effective treatment for minorities (Surgeon General, 1999). This has been partly based on the general consensus that minorities tend to underutilize the mental health system. However, Neighbors, et al (1992) stated that all groups in America underutilize mental health services based on psychiatric morbidity. Despite these differing interpretations of African American underutilization, the combination of increased risk of psychopathology and underutilization of mental health services presents special concerns for the African American population.

The general consensus is that African Americans are underrepresented in mental health treatment. However, there have been mixed findings of African American utilization of mental health services (Snowden, 1999). Cooper-Patrick, Crum, Powe, Pratt, & Ford, (1999; cited in Snowden, 2001) found that all groups were seeking treatment more than in the past and that African Americans are no longer less likely to seek treatment than Whites. However, it has been found that White Americans use mental health services more than African Americans (Snowden, 1999). Thus, Snowden (2001) reports that the utilization gap has decreased for African Americans, but they continue to be underrepresented. He explains that African Americans are less likely than White Americans to seek mental health treatment.

Neighbors (1985) reported that in a national survey of African American households that only 9% of the respondents reporting personal problems sought some type of mental health service, such as a community health center, psychologist, or psychiatrist. Most of the respondents sought help from their private physician or their minister. Seventy-six percent (76%) of those citing that they had been at the point of a nervous breakdown at some point in their life reported that they did not seek help from a mental health practitioner at all to treat the problem. The study also revealed that the

respondents were less likely to seek any help at all for emotional problems. Sixty-five percent (65%) of those respondents revealed that they had not sought the mental health profession for help. Thus, this study reveals that most African Americans are disinclined to seek help from mental health professionals, or any help at all, despite the need.

<div align="center">*Barriers to Mental Health Service Use*</div>

I had always lauded therapy in theory, but discovered I scorned it in private. Therapy was for wimps and complainers, or at least for people who had sufficient leisure time and money to take up a talking cure in the first place. In other words, therapy was for white people. (p. 85)

<div align="right">Erin Aubry Kaplan (2001)</div>

There have been several reasons given for the disinclination for African Americans to seek mental health help. Reasons, such as mistrust, clinician bias and discriminatory care, stigma, and cultural differences in help-seeking behavior, such as the preferred use of the traditional support network and differing coping styles are believed to play a role in African American underutilization (Surgeon General, 1999). Researchers have investigated the presence of these issues in the mental health field in regard to African American clients. However, there is a need for further investigation (Snowden, 1998).

Perceptions of the Mental Health System

Researchers and clinicians suggest that African Americans do not trust a mental health system that is perceived to be a White, middle-class institution (Diala, et al, 2001; Ho, 1987; Leong, 2001; Surgeon General, 1999). It is recognized that a history of oppression and discrimination in the United States may influence this perception. A history of racism and discrimination in the United States continues to influence African American daily life. As mentioned earlier, continued discrimination is subtler, and oftentimes referred to as invisible (Erskine, 2002; Surgeon General, 1999). Although racial tensions have eased since the Civil Rights Movement in the 1960s, there continues to be speculation that stereotypes and/or racism influences the perception of therapeutic treatment (Priest, 1991).

In addition, clinician bias has been documented in assessment, diagnosis, and treatment of minority clients (Sue, 1988; Surgeon General, 1999). In particular, there is

evidence of bias in diagnosis and treatment of African Americans psychopathology (Diala, et al, 2001; Surgeon General, 1999; Zhang & Snowden, 1999). In research studies, African-Americans were found to more likely have received a more severe diagnosis than White Americans (Murphy and Faulkner, 1999; Strickland, Jenkins, Myers, & Adams, 1988). Studies found that African Americans have been overdiagnosed with schizophrenia (Surgeon General, 1999; Snowden, 2001). Strickland, et al. (1988) also found that White therapists tended to minimize psychopathology of African American clients, as well. For example, there has been a history of underdiagnosis of depression (Snowden, 2001; Surgeon General, 1999). Lawson, Hepler, Holladay, & Cuffel (1994) reports that, in a study of a statewide mental health service, African Americans were overrepresented in inpatient hospitals due to civil commitment and overrepresented in the schizophrenia diagnostic group. They suggest that these findings are a result of misdiagnosis.

There has also been evidence of discriminatory care (Takeuchi & Uehara, 1996). African Americans are less likely to receive appropriate care for the depression and anxiety based on official practice guidelines. They are often given shorter treatment regimens and have poorer treatment outcomes than White Americans (Murphy and Faulkner, 1999; Strickland, et al., 1988). Neighbors, et al. (1992) also report that African Americans tend to be assigned to treatment modalities that are low in therapist intervention. Leslie (1995) suggests that there are institutional challenges that inhibit changes in these areas. Research and African American experience has shown that the mental health system is not prepared to provide efficient and respectful services that are free of clinician bias (Surgeon General, 1999). Snowden (2001) suggests that there is a need for further investigation into the delivery of mental health services to African Americans.

It has also been suggested that African Americans do not seek therapy due to the stigma of or negative attitude toward receiving mental health treatment (Leong, 2001; Neighbors, et al, 1992; Surgeon General, 1999). Some authors explain that African Americans tend to see therapy as something strange and as a service for crazy people (Boyd-Franklin, 1989; Ho, 1987). It has also been suggested that African Americans view therapy as a White American enterprise or something that is for weak people (Boyd-Franklin, 1995). Cooper-Patrick, et al. (1999) in a 1994 follow-up interview of

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participants of the Baltimore National Institute of Mental Health Epidemiologic Catchment Area Study examined mental health use for emotional, nervous, or alcohol/drug use problems six months prior to the interview. The respondents' psychiatric distress was assessed with the General Health Questionnaire. Factors found to be associated with seeking mental health care from a professional were African American race, psychiatric distress, having no health insurance, having a chronic medical condition, being unmarried, and not feeling embarrassed about seeking help. In multivariate analyses, only psychiatric distress continued to be associated with seeking mental health care. However, in analyses stratified by race and controlling age, education level, and having a consistent source of medical care, African Americans were found to be more embarrassed about seeking treatment than White Americans.

Despite some support for the idea that some African Americans avoid mental health treatment because of a perceived stigma, Neighbors, et al. (1992) reported that there appeared to be a growing positive view of mental health services in the African American community. Diala, et al. (2001) examined a national population based on the National Comorbidity Survey, issued between the years, 1990-1992. They specifically analyzed the responses of the participants who indicated need for mental heath services, in relation to their attitudes towards seeking professional care. The study showed that African Americans had a more positive attitude toward mental health treatment than White Americans. African American participants were more likely to respond positively to questions that asked their perceived willingness to seek treatment, their comfort in treatment, and their level of embarrassment after seeking treatment. As well, it is speculated, based on the cultural value of family loyalty that minorities may tend to be supportive of mental health treatment for family members despite issues of shame and stigma (Surgeon General, 1999). These findings suggest that the influence of stigma remains unanswered generally in the field.

African American Women

African American women experience discrimination as a racial minority, as women, and sometimes due to lower socioeconomic status (Henriques, 1995; Jordan, 1991). There are many stereotypes of African American women and expectations that have evolved since the era of slavery in the United States. African American women are expected to be strong, domineering, matriarchal (Few, 1999; McNair & Neville, 1996),

emasculating (Few, 1999; Jordan, 1991), aggressive (McNair, 1992), and promiscuous (Jordan, 1991). Some of the terms originated as stereotypes for African American women of low socioeconomic status.

African American women have learned to be strong (Boyd-Franklin, 1995). They are expected to be "superwomen (Few, 1999; Jordan, 1991)." Thus, African American women are hesitant to appear weak or vulnerable (McNair, 1992). Unfortunately, this hinders many African American women from seeking help. They may feel like they should handle their problems on their own (Jordan, 1991).

African American women often had to work when African American men could not work (Jordan, 1991). Historical records show that African American young women worked more often than White American young women (Henriques, 1995). African American women have historically been discriminated against based on race and gender in the workforce. They are among the lowest paid wage earners in America. They must work harder to stay out of poverty, which affects the lives of their family.

African American Men

African American men, despite variations in socioeconomic status, education, and values experience racism and discrimination. Historically, African American men have been denied the privileges associated with being a man in the United States, such as the right to support and protect their family (Jordan, 1991). Today, many experience "small social slights," which Franklin (1993) termed as, invisibility, which refers to how African American men are viewed and treated in public as potential criminals or as servants. They are only accepted as athletes or entertainers (Wyatt, 1999). This invisibility affects an African American man's self-esteem, identity development, and personal growth.

African American men also experience employment discrimination (Henriques, 1995). Black male underemployment and chronic joblessness continue to be a concern for African American men and their families (Bowman, 1993). Studies suggest that economic marginality affects the quality of relationships that African American men have with their families. For example, more African American children are more likely not to have an African American father present in the household. However, many African American fathers and husbands report that they worry about their performance in their family roles. African American men also report having close family relationships, having enduring para-kin friendships, and valuing religion.

Family and friends are important to African American men. In times of need, they usually seek traditional supports, such as family, friends, ministers, or fellow church members (Franklin, 1993). Many African American men do not trust the therapy process. They prefer not to self-disclose or "air dirty laundry" in therapy (Madison-Colmore & Moore, 2002). However, African American men will come to therapy for their family and children (Franklin, 1993).

Traditional Support Network

Some African Americans may choose to use more traditional forms of help, such as relatives, friends, and ministers in the church (Fischer & Shaw, 1999; Franklin, 1993; Neighbors, et al, 1992; Wilson & Stith, 1991), rather than using formal professional care. It is hypothesized that these informal support networks in the community may act as substitutes for mental health treatment (Snowden, 1998). Neighbors and Jackson (1984) found that 87% of African Americans in a national survey sought informal help for their personal problems. Using the same data, Jackson, Neighbors, & Gurin (1986) found that ninety-one percent (91%) of the respondents chose to use informal help for interpersonal problems; although, they were less likely to seek such help for emotional problems. However, Snowden (1998) reported that African Americans were less likely to seek help from family, friends, and religious support when there was mental health distress. Yet, they were more likely than White Americans to disclose mental health problems to family and friends, while receiving formal help.

Snowden (1998) used data from the Epidemiological Catchment Area Study, which performed face-to-face interviews in New Haven (Connecticut), Baltimore, St. Louis, North Carolina, and Los Angeles. He examined differences between African American and White American responses to sociodemographic factors and service utilization as related to their assessment on the Diagnostic Interview Schedule (DIS), which allowed for psychiatric assessment of the respondents based on the Diagnostic Statistical Manual of Mental Disorders (DSM-III). Even though the African Americans respondents reported a lower tendency to seek help from family and friends than the White American respondents, Snowden suggests that members of the informal network help African Americans recognize their problems and encourage help-seeking behavior, and that informal help and formal help are used complementarily. Erin Aubry Kaplan (2001) expressed this idea in an article about her experience seeking therapy, "I decided,

with the help of a few friends and family members, that some therapy might be in order" (p. 85). As evident from these findings, African Americans friends, family and religious leaders play an important role as resources to many African Americans (Jackson, et al., 1986).

Religiosity and spirituality are also important in the daily lives of African American people (Richardson, 1991). It has been noted that spirituality in the African American community has its roots in the traditional African culture (Boyd-Franklin, 1989). Based on a survey of the National Mental Health Association (1996; cited in Gray, 2002), eighty-five percent (85%) of African Americans report being "very religious" or "fairly religious. Based on the University of Michigan's National Survey of Black Americans, two-thirds of all Black Americans are church members (Taylor, 1988; cited in Hill, 1993). Based on the Black Pulse Survey, about half (48%) of Black church members attend each week. According to Jackson, et al. (1986), forty-four percent (44%) of African Americans use prayer to help with their problems and that as problems increase they increase their use of prayer in times of distress.

It has been suggested that religious values may prevent some African Americans from seeking mental health services (Ho, 1987). Seeking a family therapist may be viewed as a lack in personal trust in God (Boyd-Franklin, 1995). One African American woman in the Washington Post discussed the importance of God in the view of her problems: "At first, Renee Jackson, chalked it all up to a case of the blues, stoked, perhaps by the devil himself. So she prayed. Her father died, and the melancholy deepened. Pleas to God failed to lift her, but she feared turning to a professional therapist because of the stigma it carried among blacks" (Gray, 2002, p. B1). This woman may represent the sentiments of other African Americans, for whom religion is very important.

Churches in the African American community have been a life-sustaining and enriching force to its constituents in the community (Richardson, 1991). The African American Church is considered to be one of the oldest, strongest, and most highly valued institutions in the African American community (Billingsley & Morrison-Rodriguez, 1998). The term African American Church refers to the general traditions of Christian denominational churches in the African American community. It has been credited for protecting African Americans from the oppressive forces of society, such as racism and

discrimination (Ho, 1987; Richardson, 1991; Snowden, 2001). It actively promoted strong families and increased self-esteem during slavery and segregation (Richardson, 1991). The African American Church provided spiritual, psychological, and the social needs of the community.

Today, churches in the African American community continue to perform various functions for African Americans (Boyd-Franklin, 1989). Churches in the lives of African Americans can provide "social involvement, political activism, and emotional assurance" (Snowden, 2001). It has been suggested that the African American Church protects against low self-esteem, promotes strong family bonds, and strengthens individual and group identity. Churches in the African American community offer educational programs, parenting groups, child care, leadership development, and various other services (Hill, 1993). African Americans, however, vary in their religious affiliation and spiritual beliefs. Denominations and religious groups include Baptist, Methodist, African Methodist Episcopal, African Methodist Episcopal Zion, Presbyterian, Catholic, Episcopalian, Church of God in Christ, Seven Day Adventist, Jehovah Witness, Nation of Islam, and other Islamic sects.

In churches, religious leaders carry out the duties of the church and tend to the needs of the congregation. They are considered to be a primary source of help for African-Americans (Boyd-Franklin, 1989; Franklin, 1993; Ho, 1987; Leong, 2001; Surgeon General, 1999). They are one type of help that African Americans seek more often that mental health services (Neighbors, 1985). Richardson (1991) notes that the clergy in the African American church have played an important role in attending to the mental health, as well as spiritual issues of the congregation. He explains that they are able to have significant contact with African American families in different settings, such as church and home. He further explains that they are able to intervene at different levels and promote healthy living through various activities and educational programs in the church. It is posited that religious leaders can be a resource to mental health professionals in the collaboration of services for African Americans that enter the mental health population.

The African American family has also been cited as a significant traditional source of support (Boyd-Franklin, 1989; Franklin, 1993; Leong, 2001). Strengths of the African American family include: strong kinship bonds, strong work orientation,

adaptability of family, strong achievement orientation, and strong religious orientation (Hill, 1993; Ho, 1987). The extended kinship system has been mentioned as an adaptive feature of African American culture (Hatchett & Jackson, 1993). It is multigenerational and interdependent, with its members including extended family and close family friends (Hill, 1993). The extended kinship system is considered to be a heritage of West African culture and an adaptive response to oppressive situations in America. It is viewed as a resource for individual and familial coping. However, Jordan (1991) explains that in an increasingly transit society, many African American families no longer live in close geographic proximity. Thus, it is suggested that decreased access to extended family and church family has contributed to an increased incidence of psychological distress among the African American community.

Close friends and neighbors are also included as a traditional support network for African Americans (Boyd-Franklin, 1989; Leong, 2001), and are included under the concept of extended kinship network (Hill, 1993). Some close family friends are referred to as fictive kin in the literature. Fictive kin are non-related friends that function and are regarded as relatives. They are often given family titles, such as "cousin," and are sometimes closer than blood relatives. As cited previously, 87% of the respondents of the National Survey of Black Adults reported that they sought help from at least one member of their informal network, which includes family and friends (Jackson, et al, 1986).

Coping Style

It has also been noted that cultural groups have differing values around how to handle problems (Surgeon General, 1999). It has been suggested that there are cultural differences in the way that African Americans handle problems. Furthermore, it has been suggested that African American coping styles affect inclination to seek help for mental health problems.

Research has illuminated unique coping styles in the African American community (Jackson, et al., 1986). The Surgeon General (1999) reports that many African Americans show a tendency to minimize their level of distress and choose to "prevail in the face of adversity." It is believed that African Americans have learned to tolerate significant distress due to a historical life of adversity. They have learned to value the endurance of suffering (Redfearn, 2003; Ho, 1987). This type of coping

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method has been labeled, "John Henryism" (Leong, 2001). It is a "belief that obstacles can be overcome through heroic striving" (p.182). Jackson, et al. (1986) reported that 25% of a national sample of African Americans cited that facing the problem helps them in times of distress. Based on a national survey conducted by the National Mental Health Association (NMHA; 1996; cited in Gray, 2002), it is reported that 27% of African Americans would prefer to handle a mental illness problem themselves, rather than seek help. This coping technique of "John Henryism" has been cited as a reason for African American underutilization of mental health services (Ho, 1987; Surgeon General, 1999).

African American Utilization of Mental Health Services

Some authors suggest that African Americans are using therapy in increasing numbers (Hines & Boyd-Franklin, 1996). Research demonstrates that African Americans have been using mental health treatment in increasing numbers since the 1960's (Ho, 1987; Neighbors, et al, 1992; O'Sullivan, Peterson, Cox, & Kirkeby, 1989; Zhang & Snowden, 1999). In fact, O'Sullivan, et al. (1989) found that African Americans used mental health services at comparable rates with White Americans. However, African Americans have demonstrated unique patterns of mental health usage.

Utilization Patterns

Many African Americans enter the mental health system through the medical system after a crisis (Redfearn, 2003). They have higher emergency service use rates than White Americans (Hu, Snowden, Jerrell, & Nguyen, 1991). Neighbors, et al. (1985) found that second to seeking a physician, that African Americans use the hospital when they are suffering from emotional problems or a potential nervous break down. The Surgeon General (1999) also found that African Americans demonstrate a higher usage of hospitalization. In addition, African Americans have been found to be overrepresented in the inpatient psychiatric facilities (Lawson, et al., 1994; Surgeon General, 1999).

African Americans use physicians more often than any other form of professional help (Neighbors, 1985; NMHA, 1996; cited in Gray, 2002). Neighbors, et al. (1985) found that 35% of African Americans in his study of a national sample of African Americans sought help from a physician. Research also shows that African Americans report more somatic complaints than White Americans (Zhang & Snowden, 1999). These somatic symptoms are related to increased help-seeking behavior among African

Americans (Snowden, 1999). Yet, the source of referral for mental health care is least likely to be a physician.

African Americans tend to be underrepresented in outpatient mental health care (Hu, et al, 1991; Surgeon General, 1999). When African Americans use outpatient care, they are more likely to use the services from the public sector (Neighbors, et al.; 1992; Snowden, 2001). However, it is less likely that African Americans are self-referred but more likely referred by schools, courts, hospitals, or social welfare agencies (Boyd-Franklin, 1989). They are less likely to seek help from private practice, even after controlling for socioeconomic status (Snowden, 1999). However, when they enter the private sector, African Americans are seen less often and have a shorter length of treatment (Neighbors, et al.; 1992; Snowden, 2001).

Dropout

"I stopped going to the therapist eventually because I couldn't afford it (p.93)."

Erin Aubry Kaplan (2001)

When African Americans enter the mental health system, they demonstrate a higher risk of premature termination of treatment (Snowden, 2001; Strickland, et al., 1988). In addition, African Americans have been found to attend fewer sessions of treatment than White Americans and other groups (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). This is of concern because poorer treatment outcome has also been related to drop out (Gray-Little & Kaplan, 2000). Bischoff and Sprenkle (1993) in a review of marriage and family therapy drop out research found higher dropout rates for African Americans than for European Americans. In addition, Hu, et al. (1991) demonstrated in a ten-year review of public mental health service use by African-Americans that African Americans continued to fail to return after one session more often than did White Americans.

In contrast, O'Sullivan, et al. (1991) found that African Americans did not have a significantly higher drop out rate than White Americans. Also, Neimeyer and Gonzales (1983) reported that they did not find a higher incidence of dropouts for the non-white group, which includes African Americans. Neighbors, et al. (1992) reported that more recent research has cast more doubt on this theory that African Americans have a higher drop out rate than White Americans. When Viale-Val, Rosenthal, Curtiss, and Marohn

(1984; cited in Bischoff & Sprenkle, 1993) controlled for socioeconomic status they found that European Americans had a higher dropout rate.

There have been several explanations cited for the observation of high dropout rates for African Americans in some studies. These explanations are: racial differences, unavailability of African American therapists, mistrust, insensitivity to racial differences in the therapist-client dyad, and different expectations of treatment. Factors in the therapeutic relationship are essential to African American utilization. Neimeyer and Gonzales (1983) state that if therapists fail to recognize the different values, behaviors, beliefs, and expectations of clients of racially or ethnically different backgrounds, they risk hindering effective treatment. Thus, some researchers and clinicians advocate hiring minority therapists to decrease drop out (Neighbors, et al, 1992), while others advocate for multicultural training (McGoldrick & Giordano, 1996; Wilson & Stith, 1991).

Therapeutic Relationship Factors

I began talking, but after five minutes or so I felt I had said too much…It was especially important to be a rock in front of whites, who were all too eager to consign you to dysfunction anyway. So were black people, though for entirely different reasons (p.86).

Erin Aubry Kaplan (2001)

As much as 30% of the variance in psychotherapy outcome is related to variables in the therapeutic relationship. Relationship factors such as therapist acceptance, non-possessive warmth, positive regard, affirmation, and self-disclosure have been reported by clients in therapy to be important to their therapeutic success (Miller, Duncan, & Hubble, 1997). Logically, families that do not continue therapy are "not in the running" for the label of "successful therapeutic outcome." Thus, premature termination can be viewed as a failure in the establishment of a successful therapeutic relationship, and several factors in the therapeutic relationship may contribute to this phenomenon.

Only a few studies have been able to shed light on the factors influencing the suspected high dropout rate for African Americans. Researchers in the marriage and family therapy field and individual psychotherapy field have evaluated client sociodemographic variables, client values, therapist-client racial/ethnic mismatch,

counselor preference as function of client racial identity, and client perceptions of treatment as a function of race or ethnicity.

Client Socioeconomic Status

Neighbors, et al. (1992) suggests that lower socioeconomic status of the client is related to dropout. As mentioned earlier, African Americans have larger numbers of its population in the lower socioeconomic status than the White American population and lower socioeconomic status is related to higher prevalence of mental disorders (Surgeon General, 1999). Also, African American poor have a higher prevalence of mental illness than White American poor (Snowden, 2001). In their review of marriage and family therapy drop out literature, Bischoff and Sprenkle (1993) report that socioeconomic status rather than African American race is more predictive of drop out.

Client Values

Others have indicated that differences in client worldview may influence treatment outcomes. Fuertes (1999) in an experimental design study analyzed potential client perceptions of counselors, based on therapist race and accent, and "anticipated" counseling relationship. They measured Universal-Diverse Orientation (UDO) of the potential clients to determine its influence on their perceptions of the counselors. The UDO theory refers to "an attitude of openness, tolerance, and appreciation of both differences and similarities, including race, gender, sexual orientation, and physical disability" (p.124). The potential clients were Asian American and African American college students who were randomly assigned to one of six different experimental conditions, therapist race (White Hispanic, Mestizo Hispanic, or Black Hispanic) by therapist accent (English with or without Spanish accent). Results indicated that participants with higher UDO scores reported stronger "anticipated" working relationships with the counselors and greater willingness to participate in long-term therapy. African Americans with a higher UDO score rated "anticipated" working therapist-client relationships significantly higher than African American participants with lower UDO scores. Higher UDO scores were interpreted as having higher multicultural awareness and being more open to new experiences and diverse social encounters.

Therapist-Client Racial/Ethnic Matching

Some studies support the notion that the race of the therapist influences the client's decision to discontinue treatment. Thompson and Cimbolic (1978; cited in

Okonji, et al., 1996) argue that African Americans who terminate treatment early are influenced by counselor preference and counseling style. Okonji, et al. (1996) used a simulated counseling session on video to evaluate preference of an African American counselor or White American counselor using either reality therapy or person-centered therapy. The participants were randomly selected from a Job Corps program. Demographically the sample was all African American males from a low socioeconomic background. Accordingly, Okonji, et al. found that the African American participants preferred counselors who were of similar ethnicity and used a more directive approach or active counseling style. Other researchers and clinicians have also supported that African Americans prefer a more directive or active counseling style that focuses on resolving the problem (Bean, Perry, & Bedell, 2002; Kurilla, 1998).

Yeh, Eastman, & Cheung (1994) found that ethnic match was a significant predictor for dropout for African American adolescents in a community mental health center. They examined treatment effectiveness in relation to ethnic and language match of therapist and client dyads. The study used client information from a community mental health agency. The clientele included African Americans, Asian Americans, White American, and Mexican American children and adolescents. The results in regard to African Americans showed that if African American clients had a counselor of the same race or ethnicity they were more likely to continue treatment. Snowden and Hu (1996) examined the countywide utilization of community mental service programs by non-White clients in relation to the proportion of the clinicians that were non-White in the specific agency. They analyzed client information on service use during the years 1987-1990. They found that in a minority-serving mental health program with larger numbers of minority staff there was a higher utilization of services by African American clients. In contrast, Sue, et al. (1991) found that ethnic match was related to decreased chances of drop out for Asian Americans, Mexican Americans, and White Americans, but not for African Americans. Neighbor, et al. (1992) proposes more research of the interaction of ethnicity, socioeconomic status, and early termination.

However, literature suggests that some African American clients prefer African American therapists (Neighbors, et al., 1992; Snowden & Hu, 1996). For example, Terrell and Terrell (1984) indicate that African Americans with a high level of mistrust tend to prefer African American counselors over European American counselors. It has

been suggested that African American clients fear disclosure in front of European American therapists, a phenomenon often called "healthy cultural paranoia" (McNair, 1992). Other studies indicate that African American clients, for fear of having to face a lack of understanding and receptiveness and to deal with racial myths and misunderstandings with European American therapists, prefer African American therapists (Gregory & Leslie, 1996). In addition, while Gary and Kaplan (2000) indicated that African American participants preferred to have an African American practitioner, they found that almost 88% of those participants also reported that they would return to their non-African American practitioner if given an option.

Racial Identity

"Race would upset the balance of this new relationship that was forming so comfortably. It was forming, I reasoned somewhere deep within myself, precisely because I wasn't leading with experiences tied to color" (p.93).

<div align="right">Erin Aubry Kaplan (2001)</div>

Similarly, racial identity has been suggested to be an important factor in therapeutic outcome. For many African Americans, their self-identity is impacted by their racial affiliation (Boyd-Franklin, 1993). McGoldrick and Giordano (1996) explain that there is a growing acknowledgement of the significance of positive ethnic and racial identity development to clients, as well as successful therapeutic outcome. As discussed previously, racial identity influences an individual's perceptions of how much race contributes to their experiences of contexts in which race is a more prominent variable. A therapeutic relationship with a non-African American therapist can be viewed as a racially salient experience, thus influencing African Americans' preference for a same-race therapist.

Racial identity has been examined in regard to racial/ethnic counselor preference. Helms (1984; cited in Gary & Kaplan, 2000), in an examination of racial identity stage and preference for counselor, discovered that African Americans who have attitudes toward their own race and other groups that are similar to those of the dominant society are least likely to prefer same-race counselors. In other words, those with a more acculturated worldview did not prefer counselors that were racially similar. Similarly, Morten and Atkinson (1983) suggested that the reasons for mixed findings in African American preference for African American therapists is the lack of analysis of intra-

group variables. Using African American college students, they examined African American client preference for same-race therapist in relation to racial identity development, based on the Minority Identity Development (MID) model. They asked the participants to choose their preference for therapeutic variables such as therapist race, style, gender, and treatment focus. The results showed that the majority of the students who, based on the MID, espouse primarily minority values preferred an African American counselor to a White American counselor. Many of the students, who were self-identified as espousing values from both the minority group and the dominant group, stated that they did not have a preference. Also, they found that none of the students reported a preference for the White counselor.

In addition, counselor preference is related to in-group preference. Penn, Gaines, and Phillips (1993) asserts that, despite the perception of some researchers that own-group preference represents healthy racial identity development, people with a highly developed sense of identity are able to see the positive and negative characteristics of both their in-group and the out-group; thus they select from a variety of cultures the characteristics with which they prefer to identify. These authors suggest that as individuals age they focus less on overt physical characteristics and place more value on internal individual characteristics. It is posited that those who are able to reach that point in their self-identity where they step outside the "ethnically imposed limitations" are representative of courage and maturity. Thus, African American clients may differ on in-group preference.

Boyd-Franklin (1989) has also explained that African American clients vary in their preference for counselor race. She explained that African American clients consider the warmth, genuineness, skin color, race, and perceived socioeconomic status in their evaluation of their comfort with therapists. Boyd-Franklin iterates that person-to-person connection and respect is important to African Americans clients. She suggests that African American clients may prefer White American therapists and may be suspicious of African American therapists that are associated with a perceived White American mental health institution.

My fiancé, to whom I had confessed this racial reticence, declared that I must make exactly the same confession to the therapist if I was going to make real

breakthroughs. That's how the stuff worked. Her reaction, my fiancé said, would be critical: "Then you'll know if she's really any good or not" (p. 93).

<div align="right">Erin Aubry Kaplan (2001)</div>

Some studies suggest that it is not the race or ethnicity of the therapist that enhances the therapist-client relationship but a perception of the therapist as trustworthy and competent (Gary & Kaplan, 2000). Ho (1987) suggests that while African Americans tend to prefer African American therapists to non-African American therapists, but more importantly they prefer competent therapists to incompetent therapists. Vera, et al. (1999) using current clients in two community mental health agencies in a ethnically and racially diverse urban area assessed the clients' perceptions of similarities and differences from their therapist, their overall perception of the therapist attractiveness, expertness, and trustworthiness, and the significance of these traits to the therapeutic relationship. Most of the therapists were White American, but the therapist sample also included Asian American, Hispanic, and African American therapists. Vera, et al. reported that the five most frequently mentioned similarities between the client and counselor were agreeableness, gender, conscientiousness, personal interests, and extraversion. The five most frequently mentioned differences were neuroticism, roles in therapy, agreeableness, gender, and education. In this study, race was not reported to be a very important factor for these clients.

It has also been suggested that regardless of the race or ethnicity of the therapist that therapy is a reflection of Eurocentric values. Malik, Worthington, and Crump (1999) questioned whether or not therapists would differ based on race and ethnicity or would they be more similar. Using a national base of diverse therapists, African American, White American, Asian American, and Hispanic, they examined their value orientations, using the Scale to Assess World Views (SAWV; Ibrahim & Kahn, 1987; cited in Malik, et al., 1999). They found those in the sample tended to have middle-class, White American values, despite 73% of the sample being non-White. Thus, a therapist, regardless of race or ethnicity, may have a differing worldview than many minority clients.

Client Experience in Therapy

Laszloffy (2000) states that client experiences tend to be discussed from the perspective of clinicians and researchers. However, she asserts that the client's experience of therapy should be informed by the voices of clients. Some research has explored African American perceptions of therapy, in regard to session evaluation and satisfaction with treatment effectiveness.

Session Evaluation

Stiles, Shapiro, and Firth-Cozens (1988) explain that the impact that a session is perceived to have by a client could be evaluated as a mediator of long-term therapeutic outcome. Session impact refers to the effects that a therapist or client experiences immediately after a session (Stiles & Snow, 1984). It includes evaluations of the session and the feelings that are consequently related to the session. Based on clients' reports, sessions that differ by counseling style are experienced differently (Stiles, et al., 1988).

The Session Evaluation Questionnaire (SEQ; 1980) was constructed to measure session impact. It measures two dimensions of session evaluation, depth and smoothness (Stiles, 2000). Depth is the experience of the session as powerful and valuable versus weak and worthless. Smoothness is the experience of the session as relaxed and comfortable versus tense and distressing. The two dimensions of post-session mood are positivity and arousal. Positivity refers to feelings of confidence and clarity, as well as happiness versus feeling fear or anger (Stiles & Snow, 1984). Arousal refers to feeling active and excited versus quiet and calm. The SEQ has been used individual therapy, group therapy, encounter group, marriage and family therapy, and supervision sessions. It evaluates the basic components of human experience, evaluation and mood.

Gregory and Leslie (1996) used the SEQ to measure client perceptions of marriage and family therapy in a University clinic by race and gender. In a review of clinic records, they evaluated clients' perceptions of the initial and fourth therapy session based on client race (African American or White American), therapist gender (male or female), and therapist race (White American or African American). The therapist sample included four African American and four White American therapists that were interns at the university clinic. The client sample included 27 African American couples and 36 White American couples.

Results showed that the racial composition of the therapist-client dyad seemed to have little effect on the outcomes of the clients that remained in therapy. However, African American female clients reported greater smoothness and positivity with African American therapists during the initial session than with White American therapists. Furthermore, African American clients rated the first session with more smoothness and positivity than the White American clients, regardless of the race of the therapist. There was also a significant effect for time. African American female clients reported decreased smoothness between the first session and the fourth session with African American therapists and increased smoothness with White American therapists. For all males, there was a decrease in session smoothness between sessions regardless of therapist race.

The researchers suggest that a double oppression may explain the difference between the African American men and women's experience of the first session or that the counselors attempted to connect with the African American males first. They also suggest that the African American female client's preference for same-race counselor and their expectations based on this preference would contribute to their experience of the therapy sessions. They also suggest that the decrease in smoothness for the African American female clients over time was related to the hard work of therapy. This study demonstrates how session impact can differ by race, gender, and over time.

Client Satisfaction

Researchers have also evaluated client satisfaction. Some studies suggest that African Americans are less satisfied with treatment than are White Americans (Warren, Jackson, Nugaris, & Farley, 1973), while other studies find that African Americans and White Americans did not show a significant difference in satisfaction (Murphy & Faulkner, 1999; Neimeyer & Gonzales, 1983). This difference in findings may reflect an influence of time and social climate. Warren at al.'s (1973) study was conducted towards the end of the civil rights movement. Thus, the influence of society at the time of a study must be taken into consideration, especially when evaluating the experience of the African American race in the United States. However, Murphy and Faulkner (1999) in analysis of records at a university clinic found that clients reported satisfaction with their experience of treatment regardless of race.

Summary

This literature review began by discussing the variance in African American reference labels and group identification. It has been suggested that treating African Americans as a homogenous group, without defining specific sociodemographic differences in African American samples, leaves research literature lacking accurate details of African American life. However, despite African Americans' intra-cultural variations in regard to religious orientation, geographic location, and racial identity, there remains a shared value system and history of oppression in the United States.

These shared experiences of racism and discrimination are believed to influence African American perceptions of the mental health system, especially as a White, middle-class establishment inherent with racial bias and discrimination. It is proposed that these views have prevented African American utilization of mental health services, despite the increased risk for psychopathology within the African American community. Some research has confirmed the African Americans have lower utilization rates than White Americans and are not inclined to seek mental health services despite symptoms of mental distress; thus, the mental health field has responded with a call for an increase in culturally appropriate mental health care and an exploration of barriers to African American mental health use. In examination of barriers, researchers have found mistrust of the mental health system, a history of clinician bias and discriminatory care in the mental health system, and a stigma associated with seeking mental health care are present in African American research samples. Also, African Americans report using traditional support networks during mental distress, while also preferring to face their problems when they arise rather than seeking therapeutic services.

However, some researchers have also documented that African Americans have a more positive view of mental health than White Americans and are using mental health services more than in the past. Yet, most African Americans continue to enter the mental health system through the emergency room, seek a primary care doctor for mental health care, and are less likely to be seen in outpatient care. Even more concerning, some researchers have reported that African Americans have a higher drop out rate than White Americans.

Although African American clients did not report greater dissatisfaction with therapy services than White Americans, it has been suggested that therapeutic

relationship variables such as, clients' socioeconomic status and values influence treatment outcomes. Also, some researchers found that African Americans prefer African American therapists, while others note that African Americans vary in their preference for a same-race therapist. Specifically, researchers found counselor preference to be related to racial identity and worldview of the client. Research and theorists suggest African Americans that are open to the values of other cultural groups, including African American cultural values, are less likely to prefer an African American therapist. Also, a therapist's trustworthiness and competence were found to be more important than race in the therapeutic relationship. In possible support of the idea that the race of the therapist is not important for successful therapeutic outcome, in one study, the outcomes of African American clients that remained in therapy were not differentially affected, even though there was some evidence that some African Americans may be more comfortable with African American therapists.

CHAPTER THREE: METHODS

Design of the Study

I used a mixed methods approach to explore the experience of African American clients in marriage and family therapy. A mixed methods approach allowed me to view a broader picture of the African American participants' lives and experience in marriage and family therapy. I used primarily a qualitative design. Quantitative methods were used to supplement the qualitative data.

Qualitative methods involve collecting "observational or verbal data that are analyzed inductively" (Sprenkle & Moon, 1996, p. 9). I implemented a qualitative design to create a rich description of eight African American clients' experience of the therapeutic process at a university clinic. Semi-structured interviews were used to gain understanding of the African American client's experience in therapy, including their personal perceptions during the initiation of treatment and their reasons for continuation or discontinuation of therapy at the university clinic. Qualitative methods allowed me to examine clients within their own context, with that context being their own language and meaning.

Phenomenological research, a form of qualitative research, "relies heavily on in-depth interviews for data collection and is particularly useful when researchers want to investigate insider perspectives – one or more individual's perceptions of the world and the meaning that they make of events" (Sprenkle & Moon, 1996, p.11). Through an interview format, a qualitative design permitted me to come closer to the data (or the meanings provided by the participants) and look for the meaning of the phenomenon being studied as it relates to those directly involved. In other words, I was directly involved in the discovery of the data and the meaning of being involved in marriage and family therapy at a university clinic as an African American.

Quantitative methods, self-report measures and a review of existing records, allowed me to get a wider picture of the African American clientele, in regard to their experience of sessions at the university clinic. They allowed me to develop a reference group, non-African American clients, with which to compare the participants of particular interest, African American clients. Specifically, quantitative methods allowed me to test for significant differences between African American clients' and White American clients' experience of the sessions. In addition, statistical analyses of the

interview participants' responses to self-report questionnaires also allowed me to determine within-group differences. This would capture a wider picture of the experience of the therapeutic process, using subjective and objective data.

Setting

Most of the research took place at a university clinic. The university clinic is a part of a COAMFTE accredited Marriage and Family Therapy program, which trains master's and post-master's students. The university clinic is used as a training facility for the master's and post-master's students. It is set-up with a live supervision system, which includes a one-way mirror, video recorders, and a phone in every room to allow the licensed supervisor to observe, and give direct and immediate feedback concerning the students' work.

This university clinic is located in the Washington, D. C. area in a diverse community; thus, it serves a diverse population. This university clinic has been providing mental health services to the community since 1986 (Ward, 2002). It provides individual, marriage, and family counseling for a range of presenting problems, including marital conflict, personal enrichment, school problems, child behavior problems, and single parenting issues. It also provides a sliding fee scale for payment which permits the clients to pay according to their level of income. However, the university clinic does not accept insurance as a form of pay.

Participants

I purposely and conveniently selected the participants for this study from the client population at a university clinic in the Washington, D. C. area of the United States. The first phase of the study, which involved self-report questionnaires, used purposive sampling. The second phase, which included the face-to-face interviews, used a criteria-based sample.

For the first phase of the study, I used a purposive sample. All clients beginning treatment services at the university clinic were requested to participate in the study. Seventy-seven (77) clients who signed consent forms and turned in completed and valid questionnaires were included in the study. Only two questionnaires were considered invalid due to unintelligible responses. In the overall sample, 46% were males and 54 %

were female. The ages ranged from 22 years old to 66 years old. The majority of this overall sample was White American, representing 66% of the participants. Eighteen percent (18%) of the sample was African American and 14% were Hispanic/Latino(a) American, Asian American, Middle Eastern, or African.

I also used a reference sample for this study. I extracted this sample from the overall sample and only included African American and White American participants in the study. In this sample, 81% of the participants were White American and 19% were African American. In regards to gender, 47 % were male and 53% were female. Also, most of this sample (75%) had completed at least some college. Further details about this sample will be discussed in Chapter Four.

The sample for the second phase of the study, which included face-to-face interviews, was criteria-based. The criteria for participation included being an African American adult and a client that commenced treatment at the university clinic. The first eight African American participants who consented to participate in the interviews were included in phase two of the study. The sample included eight African American former or current clients at the university clinic. These participants were self-identified as African American or Black, and or identified by their therapist as African American or Black. Three (38%) were male and five (63%) were females. All interview participants reported having at least some college or technical school training.

I included the therapists at the university clinic as participants in the study. They facilitated the recruitment of client participation and their sociodemographic background information was used as data for the study. The therapist interns were asked to facilitate the study by offering all their clients the opportunity to participate in the study. They were informed that this researcher was interested in the experience of the university clinic clientele. The therapists were not notified of the specific purpose of the study to avoid tainting the data.

There were 12 therapists that were involved in the study. Three (3) were male and 9 were female. They came from various racial and ethnic backgrounds, including White (non-Hispanic) American, White- Hispanic American, White-Jewish American, African American, and Asian American. They used various models of therapy to guide their work. All therapists were interns and enrolled in a marriage and family therapy program. Ten (10) were enrolled as master's students and 2 were enrolled as post-

master's students. The two post-master's students had clinical experience previous to enrollment in the program. Four of the master's students had at least one year of experience in the university clinic, while six were in engaging in their first year of experience. However, all therapist interns have had some previous contact with the mental health population and have had at least one year of instruction before seeing clients.

I submitted a proposal to the Institutional Review Board (See Appendix H) of the university to make sure that this study is in accordance with the guidelines for research with human subjects. I took steps to ensure that there was informed consent, promises were kept, and no harm was done to the participants. I believe that this research benefited the participants by empowering them and benefited society by increasing awareness of the experience of African Americans in therapy.

Procedures

I primarily collected data through in-depth, person-to-person interviews; however two short questionnaires were used also. Informed consent was obtained from all clients at the university clinic who agreed to participate in the study. They were told that the study desired to evaluate their experience in therapy. After they signed the consent form, the therapist asked them to fill out the Session Evaluation Questionnaire (SEQ; Stiles, 2000) after the first and third sessions. Next, the African American clients that consented were contacted by phone and offered to participate in the face-to-face interviews. Finally, in-depth interviews were arranged and conducted with the volunteer clients that met the specified criteria.

For the purpose of this study, I asked the university clinic staff to implement new, temporary procedures. I contacted the staff of the university clinic and I received permission for the university clinic to be used as the setting. The staff also agreed to make some changes to the intake process. The "Background Form" (See Appendix C) was altered to include more demographic information, such as race/ethnicity, education, family income, and identification of all adults in the families that were participated in therapy. Also, a "Checklist Form" (See Appendix D) was added to the intake procedures for the therapist interns to use for all in-coming clients. It requested demographic information, such as the client name, age, gender, and race. The form also asked the

therapist to check-off whether or not the therapy participants consented to participate, whether or not they had been given a SEQ questionnaire, and whether or not all adults over 18 years old were given the opportunity to participate in the study. The SEQ (See Appendix B), an envelope for SEQ, and the "Checklist Form" were added to the new intake packets.

Prior to the implementation of the new intake procedures for the study, I met with all the participating therapists and supervisors. I informed them of the generic purpose of the study and they were also given the new instructions for the new intake procedures. I explained all the forms to the therapist interns. Then, I gave them my contact information to discuss any unanswered questions or address any unforeseen problems. Also, a box was placed in the university clinic office specifically for the study. In this box, I requested the therapists to put all completed forms and correspondence in regards to the study.

All clients upon admission into the university clinic received written information, copy of the informed consent, requesting their participation in the study during their initial visit with the therapist intern (See Appendix A). They were informed that the study was a two-part study that involved a self-report questionnaire to be completed after their first and third sessions. Also, they were notified that they may or may not be selected for the face-to-face interview, for which they would be financially compensated with twenty dollars. Importantly, this written information also specified the client's right to refuse to consent at any time during the study. Upon consent, they were asked to sign the informed consent form. They were reminded that their confidentiality would be protected from the therapist.

I requested that the therapists ask each consenting client to fill out the Session Evaluation Questionnaire (SEQ) at the end of the first session and fill out the SEQ, again, after the third session, to measure the client's experience of the therapeutic relationship. There was an area provided on the SEQ for the client to fill out their case number, gender, age and date at the top of the form. (Their names were purposely omitted from the form.) Next, the clients were instructed by the therapists to put the SEQ's in an envelope provided by the therapist. Previous to giving the client the envelope, the therapists filled in information in the spaces provided on the envelope to designate the case number, the session number, and the date. Finally, the clients were instructed by the

therapist to put the sealed envelopes in a gold-colored box designated as "sealed envelopes."

On a weekly basis, I collected the checklist forms and created files for the clients that consented to participate, in order to keep track of their informed consent forms, corresponding checklist forms, and SEQ's. It also allowed me to track each participating client's placement in the study process. Previous to the client participant's third session, I put notes in their therapist's university clinic office box to remind them to give the client the SEQ for the third session. I also checked the termination checklist in the university clinic office regularly to determine which cases had been terminated or discontinued.

I contacted the African American clients who consented to participate by phone after at least five sessions to request their participation in a face-to-face interview. This allowed the participating client to develop a therapeutic relationship and become familiar with the treatment process at the university clinic. If a participating client terminated services before a minimum of five sessions, they were contacted after their expected fifth session and after the therapist completed the termination paperwork.

During the initial phone contact with the potential interviewee, I identified myself as a researcher at the university and reminded them of the study for which they consented to participate. I explained that they had been selected to participate in face-to-face interviews for the second phase on the study. Next, I explained the purpose of the interviews in terms of the interest in African American clients' perception of treatment at the university clinic. Then, I reminded the potential interviewees of their right to refuse to participate at any time during the study and that knowledge of their participation would remain confidential. I also explained that they would be compensated for their time. Finally, if they consented, a place, day, and time were set-up for the interview.

I informed the participants of the procedures taken to keep their information confidential, such as replacing their names with pseudonyms and having personal information stored in locked cabinets in the office at the university. I also included information on the circumstances that may require breaking confidentiality. Again, I stressed that participation was voluntary and that they could withdraw from the study anytime.

There are many ethical considerations to take into account when considering a phenomenological approach to a research question. I remembered that interviews affect participants, emotionally. Interviews are personal and interpersonal. The self-reflection involved in interviews can be enlightening, inspiring, and affirming; however, they can be unsettling, disturbing, and change inducing, also. Information may be disclosed about sensitive issues, thus it was imperative to have informed consent and protect confidentiality (Boss, Dahl, & Kaplan, 1996). However, informed consent is complicated by the nature of open-ended interviews. I could not know exactly where the interview would lead. I took measures to handle boundary ambiguity, by reminding the participants of the focus of the interview and the role of the researcher, which excludes the role of a therapist; thus, avoiding the appearance of dual relationships.

To encourage participation, I gave the interviewees the option to be interviewed in their home or interviewed outside of their home. I conducted 7 interviews with 8 interviewees. Most (4) of the interviews were conducted at the university, two were conducted in the participants' home, and one was conducted at a local library. The interviews involved as many African American adult family members (who participated in therapy) at the same time, as possible. I preferred to interview adult family members or couples together. One couple was interviewed together. The rest of the interviewees were individual interviews, due to the interviewee being in individual therapy, being the only adult involved in family therapy, or the only African American adult in the family or couple. Please refer to Chapter Four for demographic information of interviewees.

Before the commencement of the interview, I reminded the interviewees of the purpose of the study and asked them to review the informed consent again and sign again in front of the researcher to show that they understood the study and their rights. I gave them the opportunity to ask any questions to facilitate complete understanding. Next, I gave an overview of the structure of the interview. Then, I asked them to fill-out a demographic questionnaire (See Appendix E) to supplement and corroborate existing information collected. I used the research questions discussed in the Introduction chapter to guide the interview (See Appendix F). I used an audio tape recorder to tape the interviews. Lastly, I asked the interviewees to fill-out the Multidimensional Inventory of Black Identity (MIBI; See Appendix G) to determine their perception of their racial identity as it relates to their therapy experience at the university clinic.

The interviews varied in the amount of time that they required. The time ranged from forty-five minutes to two hours. After completion of the interview, I asked the participants for permission to be contacted once more, if further clarification was needed on their experience. I also offered them the opportunity to receive a copy of the results after the completion of the study. A few of the interviewees requested to receive a copy of the results.

Instrumentation

Session Evaluation Questionnaire

I used the Session Evaluation Questionnaire (SEQ) to provide empirical data to add to the qualitative data from the interviews. It allowed me to assess the participants' affective experience of the therapy sessions. The SEQ provided statistical observation of differences of experience in the therapy sessions between and among ethnic/racial participant groups. The SEQ has been used in many different types of psychotherapy sessions, such as individual therapy, group therapy, supervision sessions, encounter group sessions, and family and marital therapy sessions. Across varied therapist and client groups, the SEQ has had reported internal consistency alpha ranges of .87 to .93 and alpha ranges of .78 to .89 (Gregory & Leslie, 1996).

The SEQ (See Appendix B) is a self-report instrument developed by Stiles (2000) used to measure session impact on two dimensions: session evaluation and post-session mood. It includes 21 items in a 7-point bipolar adjective format. Directions ask the respondents to "Please circle the appropriate number to show how you feel about this session (Stiles, 2000)." "This session was:" precedes the first 11 items on the session evaluation dimension. The following adjective pair choices are bad-good, difficult-easy, shallow-deep, for example. This measures client session evaluation. "Right now I feel:" precedes the last 10 items. The following adjective pair choices are angry-pleased, confident-afraid, and quiet-aroused, for example. These items measure client post-session mood.

Multidimensional Inventory of Black Identity

I used the Multidimensional Inventory of Black Identity (MIBI; See Appendix G) to provide a richer description of the interviewees, as African Americans. It allowed me to measure how the interviewees perceive their race to be related to their self-concept and how it relates to their experiences, particularly their experience of marriage and family

therapy. The MIBI also provides data for statistical observation of interviewee differences of experience, which may be accounted for by level of racial identification.

Sellers, et al. (1998) has operationalized the Multidimensional Model of Racial Identity with the development of the Multidimensional Inventory of Black Identity (MIBI). The Multidimensional Inventory of Black Identity (MIBI; Sellers, et al., 1997) is a self-report questionnaire that measures African Americans' perceptions of their racial identity. It consists of 7 subscales that measure three stable dimensions of the Multidimensional Model of Racial Identity (MMRI). It measures Centrality, Ideology, and Regard. Centrality refers to the extent race plays a role in a person's self-concept. Ideology refers to how the individual perceives African Americans should behave. There are four ideologies: Nationalist, Oppressed Minority, Assimilationist, and Humanist. Lastly, Regard refers to how negatively or positively an individual views African Americans (Private Regard) and how negatively or positively the individual feels others view African Americans (Public Regard).

The format of the questionnaire is in a 7-point Likert scale (African American Racial Identity Research Lab, 2003). The respondents are asked to answer to the extent that they strongly agree or disagree to 56 items. The Cronbach alpha scores for the seven subscales are as follows: Centrality (alpha = .77), Nationalist Ideology (alpha = .70), Oppressed Minority Ideology (alpha = .76), Assimilation (alpha = .73), Humanist (alpha = .70), Public Regard (alpha = .78), and Private Regard (alpha = .78). The MIBI has also demonstrated convergent validity an external validity (Sellers, et al, 1997).

Data Analysis

Qualitative Data

The data for this qualitative research were words and meanings (Boss, Dahl, & Kaplan, 1996). I collected data through the use of audiotapes. I had the audio taped interviews transcribed and I coded the transcripts through a process called the constant comparative method (Glaser & Strauss, 1967).

The constant comparative method is a constant process of categorization (Rafuls & Moon, 1996). I was involved in an iterative process of sorting and resorting, and coding and recoding of data for emergent categories of meaning. I compared the dimensions and properties of the emergent categories to other emergent categories.

Finally, I analyzed the data and looked for interrelationships between categories until one salient category was found to be an overarching category that encompasses the others. The constant comparative method required that I was surrounded by the data and constantly referring back to the data.

This constant comparative method involves processes of open coding, axial coding, and selective coding (Rafuls & Moon, 1996). Open coding is "a process of breaking down, examining, comparing, conceptualizing, and categorizing data" (p.71). Axial coding is a process of reducing and synthesizing data by determining how subcategories and categories connect. Selective coding involves a process of integrating information developed in the categories and explaining the properties, dimensions, and associated paradigmatic relationships (Rafuls & Moon, 1996). I used a modified form of the constant comparative method. The initial process of open coding in the constant comparative method was eliminated to accommodate the phenomenon being explored, which had not produced in-depth data. I began by reading each sentence and paragraph to determine the broad categories that emerged, rather than examining the data for small categories. However, this modified version allowed me to still be able to generate and connect meaningful categories from the data.

I constructed the transcripts in a fashion that permitted me to write the emerging concepts and categories on the transcript. The transcript sheet had a large right margin or an empty column to the right that gave enough room to write several concepts. I coded the transcripts phrase-by-phrase, sentence-by-sentence, and paragraph-by-paragraph. To increase theoretical sensitivity I used a routine process of asking questions. This was especially important because I was the only person analyzing the data. I asked questions, such as: a) who? b) what? c) where? d) how? d) how much?, and e) why? Additionally, I listed all possible meaning of concepts.

I began the data analysis as soon as the data was collected. The audiotapes of the open-ended interviews were used to collect the data. I recruited three individuals to transcribe the audiotapes verbatim. These three assistants also signed a confidentiality agreement to protect the privacy of the interviewees (See Appendix I).

To allow for a greater degree of integration and abstraction, I kept a theoretical memo. I used the memo to record my ideas about the relationships observed in the data analysis process. This provided the study with different resources that can be cross-

checked and compared for similarities and differences (Rafuls & Moon, 1996). The thesis committee advisor also reviewed the transcripts and reviewed the categories to check for accuracy and contributed to the process of triangulation.

Quantitative Data

The SEQ scores, demographic information, and MIBI scores added empirical data to this study. In order to determine if African American clients differ from non-African American clients and White American clients, I compared the SEQ scores on session evaluation and post-session mood between the three groups. I entered the data into the Statistical Package for the Social Sciences (SPSS) version 11.5 to perform statistical analyses. First, I used data from the demographic information to calculate frequencies and perform chi square tests in order to make comparisons between the groups. Then, I used independent sample t-tests to compare the SEQ scores between groups. Finally, I computed and compared MIBI scores between individual interviewees. No statistical tests were performed due to the small sample.

CHAPTER FOUR: RESULTS

Introduction

I examined the experience of eight marriage and family therapy clients in a university clinic. I focused on the experience of Black clients in marriage and family therapy and used face-to-face interviews to gain understanding of their perceptions of the therapeutic process at a university clinic. The information gathered from the non-Black clients, especially White clients, was used to provide a backdrop for the experience of Black clients. Please note that from this point in the thesis, I will use the term, Black, to include of Black participants who were born outside the United States.

In the following pages, I provide demographic and therapeutic information about general clientele receiving marriage and family therapy at the university clinic that consented to participate in this study. All who participated were asked to fill out a questionnaire that assessed their experience in therapy sessions, with the Session Evaluation Questionnaire (SEQ). Next, I compare the demographic and therapeutic data provided by Black and White clients. Then, I focus on the eight Black clients that consented to participate in the face-to-face interviews and to provide information about these participants. Finally, I will report the major findings from the qualitative inquiry of the experience of Black clients in marriage and family therapy at a university clinic.

Sample Description

Overall Participants

Overall 79 adults consented to participate in this study. Of these participants, 54% were female and 46% were male. Sixty-six percent (66%) of the participants were between the ages of 30 and 49-years-old. Thirty-seven percent (37%) were in the 30-year-old age range than any other age range. Fifteen percent (15%) were in the 50-year-old to 66-year-old age range. Racial/ethnic representation included White American (68%), African American/Black (18%), Hispanic American (10%), Middle Eastern (1%), Asian/Indian (1%), and African (1%).

Black and White Participants

In order to reduce the amount of confounding variables in the data analyses, Black clients were only compared to White Americans. I chose not to include other minorities due to the variation in language, which could influence their experience of therapy and interpretation of the Session Evaluation Questionnaire. Also, this would allow discussion

of similarities and differences in findings with this study and other studies with Black clientele, which were often compared to White client responses. In this group, 81% were White and 19% were Black. Fifty-three percent (53%) were female and 47% were male.

Demographic Comparisons

    Income

I used Pearson chi-square analysis to compare income levels. There was a significant difference at .043 significance level (Pearson chi-square value = 9.859). The lowest reported income was $3,000 per year and the highest income was $200, 000 per year. There were five different income levels as identified by dividing the data into twentieth percentiles. Most (42%) Black clients were grouped within the first level of income ($3,000-$18,000) or within the third level (33%; $36,000-$43,000). However, most (27%) White clients were clustered within the fifth level ($75,000-$200,000) or within the fourth level (23%; $45,000-$66,000; See Graph 4.1). Half (50%) of the White clients were within Levels 1-3; while, 92% of the Black clients are within these levels. Only 8% of the Black clients are within the highest two levels (4 and 5), while the other half (50%) of the White clients are represented in these levels.

Income Levels by Race

Graph 4.1
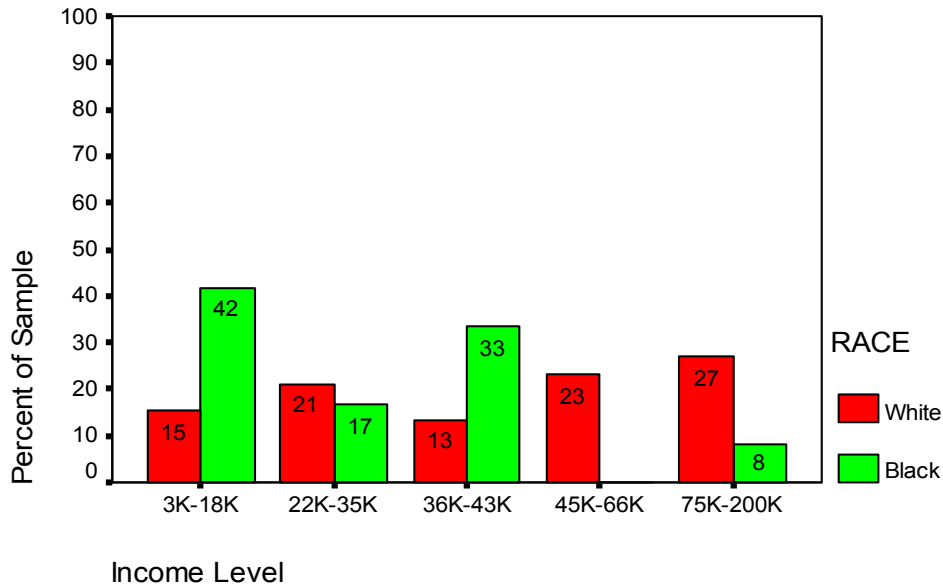
Pearson chi-square value = 9.859, *p* = .043*

* Significant at .05 level

Education

Frequencies and Pearson chi-square analyses were performed for education levels (See Graph 4.2). There was not a significant difference (Pearson chi-square value = 1.478, *p*= .687) found between Black and White clients. Overall within this group, at least 75% of the clients had at least some college experience if they had not received their college degree (See Graph 1.2). Most Blacks (67%) had at least some college experience and most Whites (78%) had at least some college, also. Two percent (2%) of White clients and 8% of Black clients had not finished high school.

Education by Race

Graph 4.2

Education Status
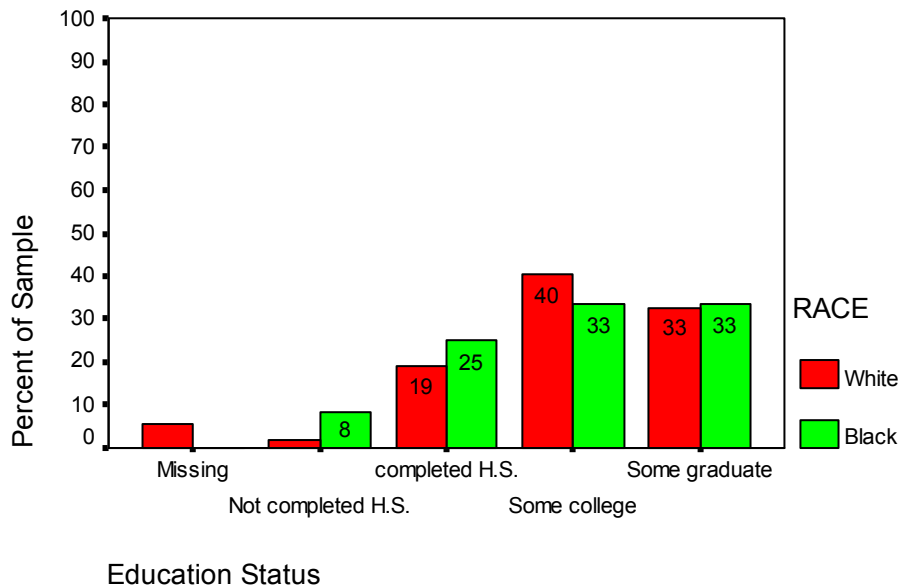
Pearson chi-square value = 1.478, *p* = .687

Age

Age comparisons of Black and White clients were also made with frequencies and Pearson chi-square analyses (See Graph 4.3). There was a significant difference found at .015 significance level (Pearson chi-square value = 10.489). The ages were grouped into four levels (1-4), ranging in age from 22-years-old to 66-years-old. Most Black and White clients (63%), together, are between 30 and 49-years-old (levels 2 and 3; See Graph 4.3). Specifically, Black clients are predominately (75%) between 30 and 39-years-old. White clients were represented more equally in all age levels with almost half (52%) between the ages of 22 and 39-years-old (level 1-2; Blacks 75%) and

approximately half (48%) ages 40-years-old and older (levels 3-4; Blacks 25%). Only 8% of Black clients were between the ages 50 and 66-years-old while 19% of White clients were of this age range.

Age Groups by Race

Graph 4.3
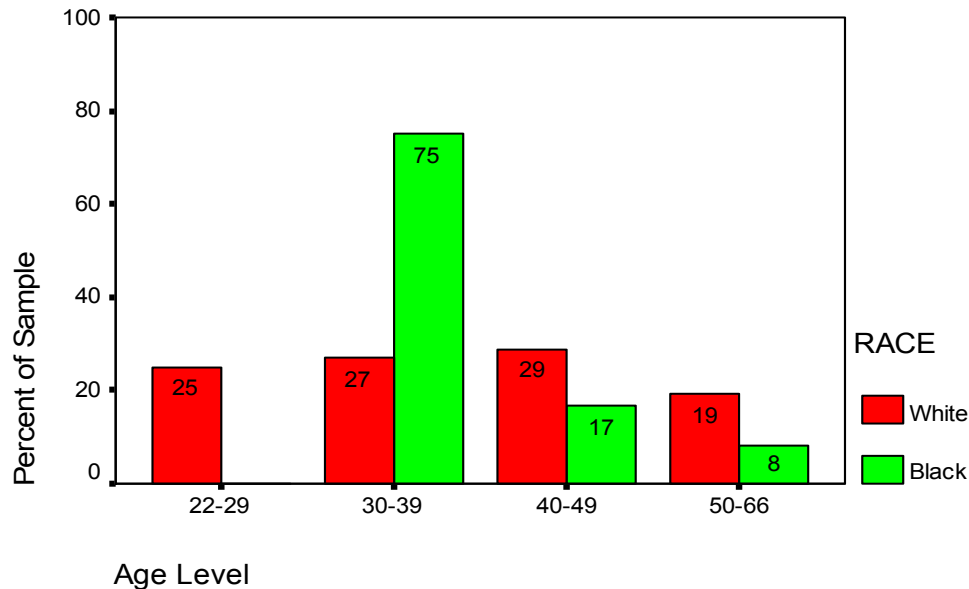
Pearson chi-square value = 10.489, *p* = .015*

* Significant at .05 level

Treatment Comparisons

Treatment Length

Quantitative analyses were also used to describe the number of sessions Black and White clients attended up until the end of the study, which also corresponded with the end of the spring semester term at the university. At the end of each semester, clients may be reassigned to therapists or therapists and their clients may decide to terminate therapy in conjunction with the end of the semester. Clients attended between 1 and 27 sessions (See Graph 4.4). These session numbers were divided into four treatment length groups, based on quarter percentiles. Clients who attended 1 to 3 sessions only were identified as Group 1. Those who attended 4 to 6 sessions were included in Group 2. Clients with a session range between 7 and 10 were identified within Group 3 and those who attended 12 to 27 sessions were within the last group, Group 4. Frequencies and Pearson chi-square analyses were performed for treatment but a significant difference

(Pearson chi-square value = .813, *p* = .846) was not found between Black and White clients. Half (50%) of White clients, and half (50%) of Black clients, attended 1 to 6 sessions (Group 1 and 2), or 7 or more sessions (Groups 3 and 4). Most Black clients (58%), versus 44% of White clients, attended 4 to 10 sessions. Also, more (31%) of White clients were present for 12 or more sessions and more (33%) Black clients attended 4 to 6 sessions.

Treatment Length by Race

Graph 4.4
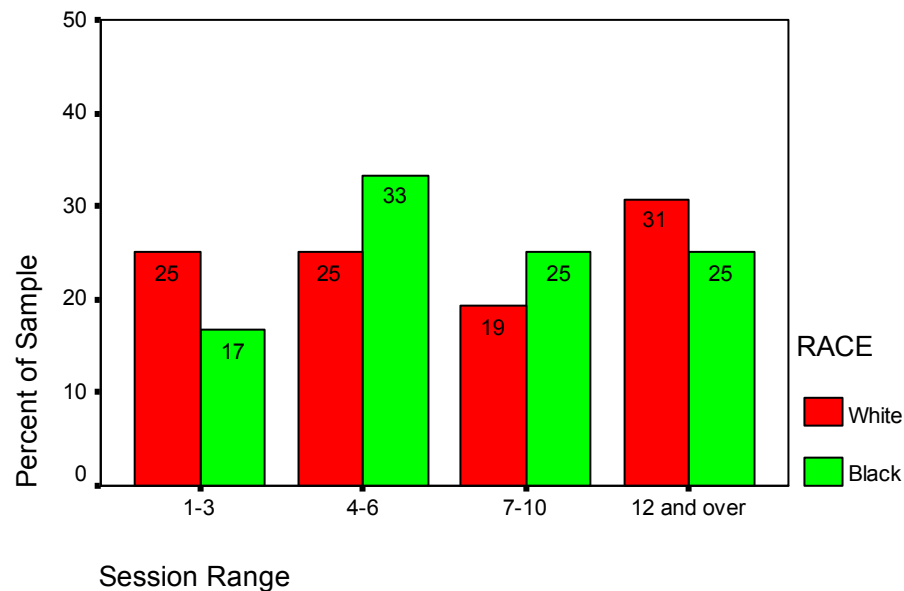
Pearson chi-square value = .813, *p* = .846

Treatment Status

As evidenced by the treatment length data provided, some clients continued therapy for many sessions while some dropped out of therapy. Most of the therapists (58%) for the Black and White clients identified their client as having "dropped" from therapy (See Graph 4.5). In other words, the therapists felt that over half of these clients discontinued therapy without their recommendation. Only 10% of the therapists identified their clients as having completed therapy, all of which were White clients. Three percent (3%) of White and Black clients were referred to another mental health provider and 31% remained in marriage and family therapy treatment at the end of data collection in May 2003. Specifically, 58% of Black clients and the same percent of White clients were considered dropouts. Also, more Black clients (42%) remained in

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therapy while 29% of White clients remained in therapy, as well. No Black clients were referred to another mental health provider. Pearson chi-square analyses did not find any significant differences between the Black and White clients (Pearson chi-square value = 2.129, *p*= .546).

Treatment Status by Race

Graph 4.5
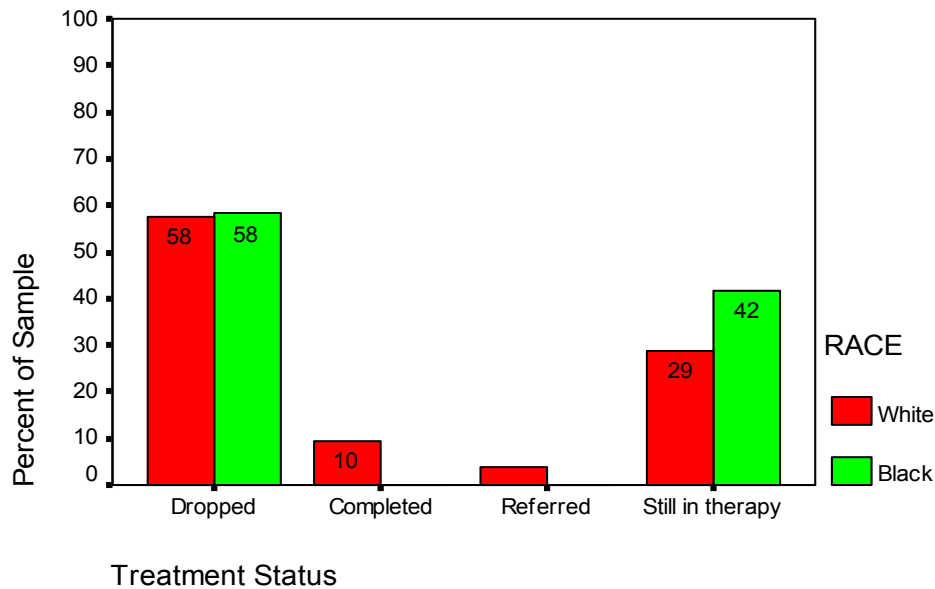
Pearson chi-square value = 2.129, *p* = .546

Session Evaluation

Finally, I compared the SEQ results for Black and White clients using Independent Samples *t*-Test. As discussed earlier, the SEQ measured session evaluation and session mood. Session evaluation included the two dimensions, Depth and Smoothness. Depth scores were based on how worthless, deep, empty, powerful, or ordinary the client experienced the therapy session to be. Scores for the level of Smoothness were based on how tense, easy, pleasant, smooth, or comfortable the client experienced the session. Session Mood also included two dimensions of evaluation, positivity and arousal. Positivity scores were based on the client's response to how sad, pleased, definite, afraid, or friendly they felt during the session. Arousal measured how still, excited, fast, peaceful, or aroused they felt during the session.

There was only one significant difference found between Black and White clients on the SEQ results (See Table 4.1). The SEQ results, for those that attended and filled

out a SEQ after the third session, did not reveal any significant differences. The SEQ results for the first session, which all clients attended, however, revealed a significant difference (*t*= 2.936, *p* value = .005) in the experience of the session depth during the first session. White clients (mean = 4.84) experienced the first session as having more depth than Black clients (mean = 4.07). In other words, the Black clients experienced the session as less valuable, deep, full, powerful, or special than did White clients. There were not any significant differences found within the other three dimensions, smoothness, positivity, and arousal.

Table 4.1

Session One SEQ Scores by Race: *t*-Test Results

	Black Clients (*n*=12)	White Clients (*n*=52)	*t*-Value	*p*-Value
	m =	*m* =	*t* =	*p* =
Depth	4.07	4.84	2.936	.005
Smoothness	4.60	4.95	.843	.403
Positivity	4.46	5.00	1.630	.109
Arousal	3.60	3.78	.670	.506

I also analyzed SEQ scores for session one by treatment status using the Independent Samples *t*-Test. Results showed a difference between clients who had dropped from therapy and clients that remained in therapy or completed therapy for session smoothness only. There were not any significant differences found for session depth, positivity, or arousal.

There was a significant difference between clients who had dropped from therapy and clients who had completed therapy at .001 significance level (*t* = 3.432; See Table 4.2). The clients, Black and White, that completed therapy experienced the first session less smooth (mean = 3.52) and the clients that dropped from therapy experienced the first session as more smooth (mean = 5.27), more relaxed, easy, and comfortable.

However, as mentioned earlier, no Black clients had completed therapy at the time of this study; so I also analyzed White client and Black client session one SEQ

scores for smoothness by treatment status, separately, using an Independent Samples *t*-Test. This helped to determine whether there was a significant difference in smoothness, in session one, by treatment status within the Black sample, also.

Table 4.2

Session One SEQ Scores by Treatment Status: *t*-Test Results

	Dropped	Completed	*t*-Value	*p*-Value
	m =	*m* =	*t* =	*p* =
Depth	4.81 (*n*=34)	4.76 (*n*=5)	.117	.908
Smoothness	5.27 (*n*=37)	3.52 (*n*=5)	3.432	.001
Positivity	5.01 (*n*=35)	4.52 (*n*=5)	1.183	.244
Arousal	3.63 (*n*=34)	3.88 (*n*=5)	-.646	.523

Results revealed a significant difference between White clients that dropped (mean = 5.267) and completed therapy (mean= 3.520) at .001 significance level (t=3.432; See Table 4.2). I also analyzed session smoothness between Black clients that remained in therapy and Black clients that dropped from therapy to determine if there was a similar difference in session one scores for smoothness (See Table 4.3). Analyses did not yield a significant difference (*p*= .087) between Black clients that dropped (mean= 5.286) and remained in therapy (mean= 3.640). However, the difference did approach significance. The same analyses, for White clients who remained in therapy and Whites who dropped from therapy, did not yield significant results (*t*= 1.018, *p*= .314). Taken together, there was a significant difference between Black and White clients that remained in therapy and those that dropped from therapy (*t*= 1.993, *p*= .051)

Table 4.3

Smoothness by Treatment Status: *t*-Test Results

	Dropped	Remained	*t*-Value	*p*-Value
	m =	*m =*	*t =*	*p =*
Black Clients	5.29 (*n*=7)	3.64 (*n*=5)	1.897	.087
White Clients	5.27 (*n*=30)	4.89 (*n*=15)	1.018	.314
Both	5.27 (*n*=37)	4.58 (*n*=20)	1.993	.051

Interview Participants

There were 8 Black participants out of the 12 total Blacks in the sample that agreed to participate in the face-to-face interviews. There were 8 interviewees and 7 total interviews. One couple was interviewed together. Sometimes, when appropriate the couple will be counted together, however, other analyses will count the couple as two individual responses.

Sample Description of Interview Participants

I gathered quantitative data on the eight interviewees to provide a richer description of their contribution to this study. I used the same demographic data and Session Evaluation Questionnaire scores gathered for the total sample, as well as additional data, such as Black identity descriptions based on their scores on the Multidimensional Inventory of Black Identity (MIBI) and other descriptive data provided during the interviews.

Five (63%) of the interview participants are female, while three (34%) are male (see Table 4.4). Five of the interview participants (63%) are between the ages of 30 and 39-years-old. Two are in their forties and one interview participant is 54-years-old. Five were currently married although one interview participant was separated from her spouse. All interview participants but one was married at some time in their life. Two had been divorced and one had never married. All were parents and actively involved in their child or children's lives. Also, every interview participant had at least some advanced study beyond high school, with only three having completed college and one finishing tech school. One interview participant had completed graduate school and one was currently enrolled in a graduate program. In regard to income, many (5) considered themselves as

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middle class socioeconomically, and three reported that they were in the low socioeconomic status.

Information from the interviews and their case files provided further descriptive information about their treatment characteristics (See Table 4.5). Half (4) were referred by community organizations or self-referred. Only three interview participants had prior therapy experiences and one had multiple prior treatment experiences before beginning services at the university clinic. Half (4) initially came for couple treatment but two came for individual treatment and two came for family treatment. Presenting problems varied with several (4) working on couple communication. A few noted that there were alcohol and drug issues (2), depression (2), or domestic violence issues (4), including physical and/or emotional abuse as presenting concerns. Many (5) had a non-Black therapist, while three did have a Black therapist before or at the time of the interview. Interestingly, there were two participants who did not recognize that their therapist was Black American. When questioned about the race of their therapist, they explained that they were not seeing a Black Therapist, despite the clinic records showing otherwise. However, I used the race of the therapist that was indicated by clinic records.

At the time of the interview, half (4) were still in treatment at the university clinic and had completed six (3) or seven (1) therapy sessions. The other half (4) were no longer receiving treatment at the university clinic. One couple (2 interview participants) had completed only one therapy session, one interview participant had completed four sessions, and one interview participant had completed five sessions during the course of this study. However, it is important to note, that the interview participant who had completed five sessions had twelve therapy sessions total at the university clinic before the interview. The participant had re-initiated services at the beginning of this study.

Interviewee Sociodemographic Profile

Table 4.4

Interview No.	Interviewee ***	Gender	Age	Marital Status	Parental Status	Education	Class Status **
1	**Sarah**	Female	40	Yes	Yes	Completed Grad School	Lower-Middle
2	**Regina**	Female	31	Yes	Yes	Some College Experience	Lower-Middle
	David	Male	34	Yes	Yes	Completed Tech School	Lower
3	**Naomi**	Female	48	Yes	Yes	Some College Experience	Upper-Middle
4	**Jeremy**	Male	30	No	Yes	Completed College	Upper-Middle
5	**Anthony**	Male	39	Yes	Yes	Some College or Tech School	Upper-Middle
6	**Edith**	Female	37	No*	Yes	Some Grad School	Lower
7	**Nadia**	Female	54	No*	Yes	Some College or Tech School	Lower

***   Pseudonyms assigned by researcher.

**   Please note that the Class Status is based on the class status that the interviewee chose on the Demographic Questionnaire.

*   Divorce

Therapy Variables at the Time of the Interview

Table 4.5

Interview No.	Interviewee	Treatment Experience	Presenting Problem	Modality of Treatment	Therapist Race	Treatment Status	Length of Treatment
1	Sarah	Yes	1	Couple	Non-Black	Continuing	6 sessions
2	Regina David	No	1	Couple	Non-Black	Dropped	1 session
3	Naomi	Yes	1, 3, 4	Couple	Black	Continuing	6 sessions
4	Jeremy	No	1	Couple	Non-Black	Dropped	5 sessions*
5	Anthony	Yes	3, 5, 6	Individual	Black	Continuing	6 sessions
6	Edith	No	2, 5	Family	Non-Black	Dropped	4 sessions
7	Nadia	No	4	Individual	Black	Continuing	7 sessions

** Please note that Jeremy "Dropped" due to separation with partner.
*   Please also note that Jeremy had a total of 12 sessions at the university clinic prior to the interview but 5 sessions from the start of the study when he and his partner reinitiated treatment.

Key
1= Couple Communication
2= Family Communication
3= Alcohol/Drug Abuse
4= Domestic Violence (Physical, Emotional)
5= Depression
6= Job-related Concerns

Multidimensional Inventory of Black Identity (MIBI)

All interview participants took the Multidimensional Inventory of Black Identity (MIBI; See Table 4.6). The scores were divided into three dimensions that produced scores for seven subscales. The three dimensions are racial Centrality, Regard, and Ideology. Possible scores ranged from 1 ("strongly disagree") to 7 ("strongly agree").

The first dimension measured centrality. Again, Centrality refers to how important race is to a person's self identity during a given situation. The scores for the interview participants ranged from 1.63 to 6.75 (see Table 4.6). The mean score was 4.72. Thus, the interview participants varied in their perception of how much their Black race was significant to their self-concept.

The next dimension measured by the MIBI was Regard (See Table 4.6). As mentioned before, Regard is related to how negatively or positively an individual views their race, personally and from the perspective of out-group individuals. The subscale scores for Private Regard ranged from 5.33 to 7.00. The mean score was 6.40. Thus, this group overall has a positive view of their race. The Public Regard subscale scores were lower. They ranged from 2.83 to 5.83, with a mean score of 4.27. Thus, this group is in the middle about how others view black people, with several perceiving positive perceptions and several perceiving more negative perceptions.

The MIBI also revealed the interview participants' beliefs about how Black people should behave and interact with other races and ethnic groups within society within the dimension of Ideology. There were subscale scores for Assimilation, Humanist, (Oppressed) Minority, and National beliefs. Again, Assimilation Ideology refers to the belief that the American identity is more important than racial identity and that association with mainstream America is important. Humanist Ideology refers to the belief that commonalities of the human race and individual qualities are more important than physical characteristics, such as race. Minority Ideology refers to a concern for the marginalization of Blacks, as well as other groups. National Ideology refers to the view of the Black minority experience as unique and association with other Blacks as important.

Interviewee MIBI Scores

Table 4.6

Participants		Centrality Scale	Regard Scale		Ideology Scale			
Interview No.	Interviewee	Centrality	Private Regard	Public Regard	Assimilation	Humanist	Minority	National
1	*Sarah*	6.75*	7.00*	4.17	5.33	**4.33**	7.00*	4.33*
2	**Regina**	4.75	6.00	3.00	5.22	5.00	**3.11**	4.22
	David	4.38	**5.33**	4.33	4.00	5.00	3.67	3.11
3	**Naomi**	**1.63**	**5.33**	5.83*	6.11	6.67*	4.22	**2.11**
4	**Jeremy**	5.50	6.83	5.17	6.44	5.56	4.89	2.78
5	**Anthony**	5.25	6.83	4.67	6.56*	5.22	4.22	3.22
6	**Edith**	3.63	7.00*	**2.83**	**3.89**	6.56	4.78	2.78
7	**Nadia**	5.88	6.83	4.17	5.33	5.56	6.44	4.33 *
Mean		4.72	6.40	4.27	5.36	5.49	4.79	3.36

* = *Highest score*

Bold = *Lowest score*

Overall, the group espouses humanist (5.49) and assimilation (5.36) ideologies, with less support for minority (4.79) and national (3.36) ideologies, respectively (See Table 4.6). The Assimilation scores ranged from 3.89 to 6.56 with the mean being 5.36. This shows that this group of interviewees leans toward Assimilation ideas. Humanist scores ranged from 4.33 to 6.67, with a mean of 5.49. These results support that this group tends to have humanist beliefs. Minority scores ranged from 3.11 to 7.00, with a mean of 4.79. Although having more variation on these beliefs, this group also shows some support for minority ideology. National scores ranged from 2.11 to 4.33, with a mean of 3.36. These scores reflect that the interview participants, as a group, show little support for national ideology.

Case Descriptions

Although the interviewees have some similarities as a group, individually they bring very unique perspectives of their experience in marriage and family therapy at the university clinic. They vary in sociodemographic background and therapeutic experience. In the following pages, I will briefly describe each participant based on information provided from the case files, the questionnaires, and the interview.

Sarah

"It was suggested many years ago and I thought no I don't need it. You know, I don't need therapy because that's, that's when I thought it was crazy people in therapy. So, and then as time went on and I thought I was fine and then as time went on, I started to see different things that I didn't like about myself and so I decided that I needed therapy."

Sarah is a 40-year-old female. She is a working professional and also carries the role of mother and wife. Sarah's husband is an immigrant to the United States. Sarah and her husband have a child together. Sarah completed a graduate degree and considers herself to be a Christian Middle-class, Black American.

Sarah and her husband were court-ordered to marital therapy although she reported in the interview that she had already been thinking about seeking therapeutic services. She reports that she and her husband had been in marital counseling at her

church before treatment at the university clinic, but she did not consider it to be therapy. Sarah and her husband initiated treatment with a non-Black therapist, presenting couple communication problems. Sarah and her husband were continuing treatment at the university clinic at the time of the interview. Sarah explained that she remains in therapy at the university clinic because she has had a positive experience and sees progress with therapy. She added that she also likes the affordable price of therapy and the flexible clinic schedule.

In regard to Black identity, Sarah scored the highest, among all interviewees, on the Centrality scale (6.75), the Private Regard subscale (7.00), the Minority Ideology subscale (7.00), and the National Ideology subscale (4.33). However, she scored the lowest on the Humanist Ideology subscale (4.33).

Regina and David

"I just want it different. I wanted my family. I wanted to be able to communicate. I wanted my kids to grow up with both of their parents around all the time, twenty-four hours."

"Now to think about therapy, therapy is something that I hope will bring things to the open, so that you can close it. Then good situation or bad situation, it's how you take it."

Regina and David were interviewed as a couple. Regina is a thirty-one year old female and David is a 34-year-old male. They have been married for 13 years and have children together. Regina has some college experience. David went to high school until the eleventh grade and then went on to finish technical school. Regina considers their family to be of lower-middle socioeconomic status, while David considers their family to be of low socioeconomic status. On the sociodemographic questionnaire both decided not to choose a preferred racial/ethnic label. They explained that racial/ethnic identifiers can be used to discriminate against people and that their own race/ethnicity did not matter.

Regina and David were referred to the university clinic by a family program that they were apart of, but had planned to seek therapy before the referral. They had not had

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any previous therapy experiences. Regina and David sought treatment to improve their couple communication, in order to keep their family together.

Regina and David had only one session with a non-Black therapist and did not return due to schedule conflict. They explained that they had a good experience in therapy; however, they had difficulties with transportation and their schedule. In regard to Black Identity, David scored the lowest, among the interviewees, on the Private Regard subscale (5.33). Regina scored the lowest on the Minority Ideology subscale (3.11).

Naomi

"African American women, I've said this to other people, are used to their men being gone, for whatever reason. And their position is that their family will not suffer. The family will go on with or without you because family has to go on. If that means the woman takes care of it, fine."

Naomi is a 48-year-old female. Although separated from her husband, she has been married for twenty years and they have a child together. Naomi self-identifies as an African American, upper-middle class woman with some college experience. She is Christian and is actively involved in her church.

Naomi and her husband had sought therapy before initiating services at the university clinic. Later, Naomi and her family were court-ordered to family therapy and referred to the university clinic by a probation officer. However, the work has been primarily with Naomi and her husband in couple therapy.

Naomi was assigned a Black therapist and they were working on the presenting issues, couple communication, alcohol and drug concerns, and domestic violence. At the time of the face-to-face interview, Naomi had attended six sessions and was still actively participating in treatment at the university clinic. She explained that she continues because she finds therapy beneficial and because she desires that her husband and daughter will develop a better relationship.

In regard to Black Identity, Naomi scored the highest, among the interviewees, on the Public Regard subscale (5.83) and the Humanist Ideology subscale (6.67). She also scored the lowest on the Centrality scale (1.63) and the Private Regard subscale (5.33).

Jeremy

"No we were happy. I was raised to solve my issues. That is what I believe. We needed to find someone to help us fix our problems."

Jeremy is a 30-year-old Black male. He is not married but was involved in a serious relationship, from which he became a father. His partner, the mother of his child, was non-Black and of a different religious orientation. Jeremy considers himself to be a Christian, upper-middle class man. He is college educated and does not believe self-identifying his race is important.

Jeremy and his partner initiated services at the university clinic for couples therapy. They had not had any previous therapy experiences. Jeremy and his partner were assigned a non-Black therapist and began addressing the presenting problem, couple communication.

They had attended seven sessions and then terminated services. Later, in correspondence with the beginning of this study, they had re-initiated services. They had attended five sessions after re-initiation of services and before the interview. They had twelve sessions total at the university clinic. At the time of the interview, Jeremy and his partner had discontinued therapy due to the break up of their relationship. Jeremy explained that he had been happy with his service at the university clinic.

In regard to Black Identity, Jeremy, among the other interview participants, did not score higher or lower on any of the MIBI scales. However, individually, he scored higher on the Private Regard subscale (6.83) and the Assimilation Ideology subscale (6.44). He scored lower on the Minority Ideology subscale (4.89).

Anthony

"I knew I needed help, had a family and it was close to Christmas. I was still stealing and needed help. Even my conscience started bothering me, so I knew I needed help."

Anthony is a 40-year-old Black male. He is currently married and is a father. He has children from previous marriages. Anthony considers himself to be a part of the upper-middle class and has some college experience, but was not able to complete his college studies. He attends a church but is not actively involved.

Anthony sought individual treatment at the university clinic. His wife has attended but he wanted to focus on individual concerns. He was assigned a Black therapist and began to address his presenting concerns, alcohol and drug use, depression, and job-related concerns. Anthony reports that he had previous individual and couple therapy experiences prior to beginning therapy at the university clinic. At the time of the interview, he was still actively involved in treatment and had attended at least six therapy sessions. He explained that he had found therapy to be beneficial.

In regard to Black Identity, Anthony scored the highest on the Assimilation Ideology subscale (6.56). Individually, he scored higher on the Private Regard subscale (6.83) and lower on the National Ideology subscale (3.22).

Edith

"I call my brother or my mom or you know whomever I choose. But it was important to me that I handled the situation; that I dealt with it. I got the information and I was able to look at the situation and decide what's going to happen with my family. So it was important to me."

Edith is a 37-year-old female, originally from the Caribbean region. She is divorced and raises her children alone. Edith considers herself to be a low-income, Black, single-parent who values church and family. She has a college education and is currently pursuing a graduate degree.

Edith had never been in therapy before, but with the suggestion of a classmate, decided to seek therapeutic services for her family. She initiated services at the university clinic and was assigned a non-Black therapist. In family therapy, she addressed family communication and depression concerns.

At the time of the interview she was no longer receiving services at the university clinic. She had decided to discontinue services after four sessions because she felt that the family had gotten over their crisis and gotten what was needed, therapeutically. She

explained that the time of the session and distance she had to travel to the university clinic also influenced her decision to discontinue services.

In regard to Black Identity, Nadia scored the highest on the Private Regard subscale (7.00) and the lowest on the Public Regard subscale (2.83) and the Assimilation Ideology subscale (3.89), among the interview participants.

Nadia

"I was just crying a lot. And I was just so torn up. It was so many questions that I needed answered. My scripture helped me to be strong and to lean on God to get through. The therapist gave me some answers."

Nadia is a 54-year-old female. She is divorced and is a mother. Nadia views herself as a low-income, African American woman. She finished high school and has some college experience. Nadia also values religion. She had previously worshipped as a believer of the Nation of Islam but now practices a traditional form of Islamic religion.

Prior to coming to therapy at the university clinic, Nadia had never received any form of therapeutic services. However, her daughter had strongly suggested that she seek therapy. Nadia took her daughter's advice and sought services. She called a hotline that referred her to the university clinic. Nadia was assigned a Black therapist and began working on her presenting issues, a history of domestic violence. She received individual therapy, although her daughter occasionally joined her. At the time of the interview, Nadia had attended seven sessions and was still receiving services. Naomi explained that she and her therapist were preparing to terminate services because she believed that she had made progress and had gotten out of her crisis. She added that she could also use her money elsewhere.

In regard to Black Identity, Nadia scored the highest among the interview participants on the National Ideology subscale (4.33). This high score may be reflective of her age. She grew up during the 1950s and 1960s. Individually, she scored the highest on the Private Regard (6.83) subscale and the Minority Ideology subscale. Also, her individual low score was on the Public Regard subscale (4.17).

Qualitative Results

The qualitative results were gathered through face-to-face interviews with the eight Black interview participants described above. A number of major themes emerged from this study. First, the interview participants discussed their prior thoughts and experiences regarding therapy, which includes the stigma of seeking therapy and preferred coping behavior. Second, the interview participants talked about the influence of family, friends, and church/religious beliefs before seeking therapy and their support during therapy. Third, the interview participants discussed their expectations and concerns about therapy prior to beginning treatment at the university clinic. Fourth, the interview participants talked about their experience of the university clinic services and physical surroundings. Fifth, the interview participants discussed their views on the importance of therapist race in the therapeutic relationship. Finally, the interview participants offered suggestions for the university clinic and advice for marriage and family therapists working with Black clients.

These themes resulted in the following major findings, which have been organized chronologically to facilitate greater understanding of the stories that the interview participants have shared. Please note that for each category many of the numbers for the findings will not equal the total number of interview participants, eight, because the interview participants did not respond to all questions. Also, some information in the quotes has been changed to protect the confidentiality of the interview participants.

Preconceived Ideas about Seeking Therapy

As mentioned earlier, many (5) of the interview participants had not had any experience in therapy prior to initiating services at the university clinic. However, there were 3 that had some previous therapeutic experience. Sarah did state that she and her husband had briefly received services from a Christian counselor. Naomi explained that she and her husband had received therapeutic services prior to their current treatment, briefly, as well. Anthony, on the other hand, explained that he had several experiences with therapy since his teenage years. He also explained that he and his former wives had sought marriage counseling at some point. He stated:

I have been in therapy a few times. I have been married 3 times and I have tried therapy for all 3 of my wives. I was in therapy at the age of 15 to 18, and also marriage counseling.

Thus, many of the interview participants came to therapy with preconceived ideas of therapy. These ideas affected how positively or negatively the participants viewed therapy. While there were some exceptions, most (6) of the interview participants believed that the Black American community does not think that it is acceptable for Black Americans to seek therapy. They talked about their beliefs, their family's beliefs and the Black community's beliefs that they should solve their own problems, rather than go to a therapist.

Stigma of Therapy and Preferred Coping Behavior

The interview participants discussed negative preconceived ideas of therapy. For example, Anthony made a distinction between Black and White people. He said:

You know Black people frown on therapy. White people don't; it's as if it is a natural way of life. They think it is a part of life. Black people think they can work it out on themselves.

Sarah shared similar impressions about African American perceptions of therapy. She recounted:

I don't think that it's normal, whatever that is, but I don't think it's normal for African Americans or Blacks to go to counseling to reveal that they need someone else's help.

Regina also discussed her lack of familiarity with therapy, how her family views therapy, and her family's preferred way of coping. Regina stated:

I have never seen how therapy was. Know what it was. That was just out of the question. I mean you just go through the motion or you go about your business. Leave that, you think you leave that behind, in my opinion, you think you left that baggage behind but it still drags on being you when you go onto another situation. So, but it was just, 'why would you go through that, going through therapy [and] having time to do that.' You get out of it; you get out, go on, and rebuild another life. It was like to me not a coward, but to me felt like you gave up. But if you did all you could do it's still not right, then that's totally different.

Further, Regina explained:

> I mean as far as my siblings and me, they were telling me as a Black, nobody could tell me anything as about my family and it's all a misinterpretation of what therapy is all about. I think if you've never been in it, and some people are afraid more than anything, and they just lash out and say negative thoughts and negative things about it, because they don't know. They aren't aware of what it really is about. My opinion about it is, it's not about the therapist dictating, it's what you and your partner try to work things out and that party is just there to be the negotiator to have things to be, set it the way how we had it. It's not the person that's putting ideas into [David's] head or ideas in my head. It's already supposed to be set in there. It's us working together to make that happen.

Naomi's family seemed to be more receptive of therapy. Naomi discussed:

> I: Have they always been supportive of therapy?
> W: Yes.
> I: It hasn't been a stigma for them?
> W: Not at all. It's just like my aunt tells me, "Do what you have to do, this is good for you." It's not like any feeling of being lesser than who I am from anybody. I think because so much of this is out there in the media and print material that. I'm serious. The stigma isn't there like it used to be. My mother used to be a psych nurse at NIH. She's like, "Well, I'm glad that you're going. That's a good thing." So it's been, I've not had any problems with anyone not supporting me.

New Views of Therapy

However, over the course of time, a few (3) of the interview participants developed a more positive and hopeful view of therapeutic services. Sarah explained her initial negative sentiments in regard to the idea of coming to therapy. She said:

> It was suggested many years ago and I thought no I don't need it. You know, I don't need therapy because that's, that's when I thought it was crazy people in therapy.

Similarly, Nadia described her thoughts about it. She explained:

> Yeah I sort of felt like that too, but that wasn't that serious for me. I knew I wasn't crazy. My daughter said it has nothing to do with you being mentally ill. You just need somebody to talk things out and to help you organize your thoughts and get you to get back on track.

David discussed a new view of therapy. David recalled:

> As a matter of fact, this is something new to me, therapy anyhow, as I became a man, older, now to think about therapy, therapy is something that I hope will bring things to the open, so that you can close it.

David also recalled:

> There's nothing that one person can tell you anything or show you anything themselves. I thought about that for a little bit. I had that perception. But I'm not going to worry about that. Another person can't tell me nothing. So and I did think of that. And I'm just getting over that. And I'm not even going to' think of that no more. Rather sit down and talk.

As an exception, there were was one interview participant that did not have negative preconceived ideas of therapy. Naomi had a more positive view of therapy. She also discussed how society's perceptions of therapy have changed. Naomi recounted:

> I think that stigma doesn't apply anymore. They [society] used to have a stigma associated with going to counseling in the past. But I don't think they [society] see that as an issue anymore - at least the people that I know. I know a lot of people who go to counseling. And it's just sort of through situations where they have someone to talk to, to work through situations, and they don't see it as a stance that you're crazy. They don't look at it that way. And I don't view it that way either. I look at it, as this, forces him [husband] to hear me. Where in other venues he would not sit still long enough to hear me so…. For me it's a positive, well, it has the potential to be a positive thing because he is forced to hear me.

Motivating Factors for Seeking Therapy

Despite initial negative preconceived ideas of therapy and some hesitation, the interview participants talked about the necessity of therapeutic services to address their concerns. Some did not focus on the stigma of therapy, but viewed the purpose of therapy as more important. They explained that they desired to protect their family, protect their couple relationships, and protect their individual lives. Thus, they were willing to be strong and disregard any negative preconceived ideas.

Strength to Overcome Hesitance to Begin Therapy

Two of the interview participants were more hesitant about going to therapy. However, they were determined to get help. Regina expressed her hesitation about going to therapy for the first time. She said:

> I felt hesitation at first. Have that vibe where you don't really want to' go. So I had to be strong enough to say that if he feels that way, then you need to go and if you need therapy for the kids then get therapy for the kids. If you need therapy by yourself, get therapy by yourself. But me, per se, or hear anything, nobody ever talked about [therapy]. Again, it was never do anything like that. It was more try other things or just get on with your life.

Crisis

There were three participants that felt that they were in a crisis and that there was a dire need for the therapy services. For example, Edith felt an urgent need to receive help for her family. She elaborated:

> Well, I felt like my family was going through a crisis, and I recently moved to the area. No family, you know, brothers and sisters and so forth, and I needed an unbiased atmosphere where both me and my daughter could speak freely about how we felt about the situation [presenting concern] at that time and somehow get to understand each other. I desperately needed that kind of atmosphere. And I somehow felt like I couldn't handle the situation. It was making me depressed, so I really needed that kind of forum so I could speak out.

Determination

Three of the interview participants were focused on the purpose of therapy, the resolution of their presenting problem. They did not consider the negative perceptions of therapy. David expressed this in the following excerpt. He recounted:

> It didn't bother me. I was looking at, you know, what we was going to' get from the program. That's all that mattered to me. You know, getting my family back together – that one unity. You know, it didn't matter.

Love of Family

Most (5) of the interview participants discussed wanting to protect their families from dissolution, neglect, and damaged parent-child relationships. The desire to protect

children seemed to be a primary motivator to seek therapy for many of the participants.

For instance, Edith proclaimed:

> I want the best for my children. You know I love them dearly; I would
> give up school right now to save my kids. I want the best for them, and so
> I just could not communicate that to them. So I thought therapy would
> say, "OK. Listen to her. She truly loves you.

Although seeking individual treatment, Anthony mentioned the importance of his family.

He said that he wanted to provide and protect his family from his behavior. He stated:

"I knew I needed help, [I] had a family and it was close to Christmas. I was still stealing

and needed help. Even my conscience started bothering me, so I knew I needed help."

Desire for Relationship Preservation

Several (4) of the interview participants were also concerned about their

relationship with their partner and desired to re-establish trust and friendship. They

wanted to renew or improve the relationship with their partner. Regina explained how

the survival of her marriage also had consequences for the children and the whole family.

She recalled:

> I think that's something that we did both agree on before we entered the
> program that we needed a third party because we weren't communicating.
> It was more hurting each other's feelings than it was talking. So there's a
> lot of feelings that's still hurting and we used to could call each other
> friends, not just lovers or boyfriend and girlfriend or husband and wife; it
> was friends first.

She continued:

> We needed to do something. We both believe in God, so it wasn't that we
> didn't pray to try to get our relationship together, but to having that third
> party I think just helps you to see things a little bit more clearly. That was
> our main goal of things. Just to make sure, you know, you wanna' have,
> it's not, you know, a lot of families break up more and more each and
> every day. We didn't want that.

Desire for Personal Growth and Understanding

Two of the participants had more personal reasons for beginning therapeutic

services at the university clinic. For example, Nadia wanted to get a better understanding

of herself and the events that took place in her life and her marriage. She recounted:

> I came in because of all my mixed emotions. The hurt, the not
> understanding why, you know he seemed like a stranger to me, like a

person I didn't know. And at the same time I still loved him. And I just needed an outlet, somebody to talk to, and I needed to find out what was his problem or what was mine, you know. What went wrong? And why?

Role of Family, Friends, and Church/Religious Beliefs

Most (7) of the interview participants described significant relationships with family, friends, and/or the church. Sarah used friends and the church as a support network but was reluctant to use her family, since she did not believe that they would be able to provide an unbiased ear. Jeremy explained that he and his partner used family and friends as a resource, and he was willing to use the church if he and his partner were of the same religion. Nadia and Naomi also expressed the importance of family, friends, and the church/religious beliefs as they dealt with their situations. Regina and David described supportive relationships with their church members. Edith was in a unique position. She was new to the area and explained that family, friends, and church would have been whom she would have sought first before therapy, if they were more readily available to her. Edith explained:

> But I also think that I wouldn't go to the [Clinic] if I had deep roots or closer attachment to religion. I think I probably would have sought help if after, you know, going to my pastor or turning to my church. If I at some point felt like the help wasn't enough or I wasn't getting what I really wanted, I probably would have sought outside help. But yeah, there is a stigma that you should pray and so forth, but the thing with therapy or the thing that I was looking for was an unbiased atmosphere. And the church gives you that, and therapy gives you that. So it's like if A doesn't work, you turn to B. If B doesn't work, you turn to C. I think, in that order, family can help, then try church. If church doesn't help you, then the therapist. That's my view on it. And it's probably what I would have done if all those three things were available to me at the same time.

Support Before Initiating Therapy

Most (5) of the interview participants said that they used self-help resources to help ameliorate their presenting concerns before initiating therapeutic services, such as making personal behavior changes, making relationship changes, and reading books. However, most of the interview participants also relied greatly on the support of family, friends, and church/religious beliefs *before* treatment at the university clinic.

Friends and Family

Several (4) of the interview participants explained that they sought their friends for advice and support before treatment. Sarah, Jeremy, Naomi, and Nadia said that used their friends as a resource. Sarah said: "We talked to friends, you know. I talked to friends that I had. He talked to some of his friends, and that was basically it."

Two of the participants explained that they sought out family members to deal with their concerns. Nadia said that she sought family and friends. Jeremy explained that he and his partner sought family, along with friends, as well. Nadia said:

> I talked with my daughter. I talked with friends. I tried to get the anger out. I talked with everybody. Me and my fiancé both had friends who were mutual friends and we would talk on the radio, you know, we were C.B. people. I got on the C.B. and I told everybody what he did to me. And anyway, I just had to get it out.

Religious Beliefs

Some (3) of the interview participants also discussed personal religious practices as helpful as they sought resolution of their problems prior to going to therapy. Regina and Nadia, particularly, felt strongly about their religious beliefs and expressed the importance of God in their lives. Edith also expressed that the use of spiritual resources were important. All three of these participants stated that they used prayer to address their problems. Only one, Nadia, also stated that she read scriptures to help her deal with her problems. Regina explained the importance of prayer as she sought problem-resolution. She explained:

> I can say for myself, I know we had to change our lives. That was bottom line and that's what I felt by prayers that's the only answers I could get is me to change. And I have to work on you as much as I have to work on him.

She also said:

> I could say that asking God what I should do, what should we do as a family. The praying just, you know, if therapy is not the way show me another way. But it never went another way. So I think it was for therapy. If there was another way, I didn't see it.

Church

All of the interview participants stated that they were affiliated with a church or religious group. However, most of the interview participants did not seek their pastor at their church prior to coming to therapy at the university clinic. Some of the interview participants were concerned about confidentiality in the church.

A couple of the participants stated that they did not consider their pastor as an option for help. Sarah explained that she was too concerned about confidentiality within the congregation. Anthony explained that he did not know his pastor well enough; thus, it was not an option. In addition, there were two participants that explained that there pastor would have been an option if their circumstances were different. Jeremy explained that if he and his partner were of the same religion that they would have sought help from the church pastor. Edith stated that she was new to her church congregation; thus, she did not want to use her church pastor for help.

Only one couple, Regina and David, chose to use there pastor prior to seeking treatment. Regina and David explained that they had unsuccessfully attempted to use their pastor and pastor's wife to help their situation. Regina and David discussed what happened. Regina said:

> We did, actually. But I don't think that everything was out in the open there. I feel that everything wasn't out in the open there, and I think there was some unease there, why it didn't come out. Not on my part, though, I feel I'm very open – I'll tell how I feel right off the bat. I don't think that maybe it made, it didn't make me, per say, uncomfortable, but sometimes when you go to your pastor or minister or whatever, per say, sometimes you feel that if you go back to church you might that you already sat out there, you know everybody already knows everything that's going on, so it makes you uncomfortable to go back to that same place.

David added:

> Yeah, it felt uncomfortable for me to talk about some things in the past what I had done or whatever. I don't know what it was. Just talking different to, you know, he was my pastor but he was also a man, too. So I just wasn't as open as much as I could have been.

Support during Therapy

Most of the interview participants also relied greatly on support of the family, friends, and church/religious beliefs *during* treatment at the university clinic. Although using some caution about disclosure of therapeutic services, the participants generally described their family, friends, and church as being supportive. Most of the interview participants felt that their church or religious beliefs did not prevent their participation in therapy, but felt that they made it easier for their participation.

Family

Most (5) of the interview participants explained that they disclosed to at least one family member. Three of the interview participants discussed a negative experience with sharing information about their therapy participation. However, two of the interview participants that acknowledged disclosure did not report a negative experience with disclosure. Regina shared her experience of her family's knowledge of therapeutic services. Regina recalled:

> Yeah, I told my mom. You know, because of it not being so known and, um, in the family, of going to marriage counseling, it was hesitation from family members about it, you know. Why would you do that, you know, um, if you pray on it, God will work it out instead of putting another person into that. I mean as far as my siblings, me, they were telling me as a Black, nobody could tell me anything about my family and is all a misinterpretation of what therapy is all about.

Several (4) of the interview participants found their family to be supportive of therapy. However, some (3) of the participants either did not find support or did not expect support. For example, David and Edith said that they did not know what their family would think but did not think that they would be very supportive, due to their negative perceptions of therapy. Edith explained:

> Now as far as my family supporting my going to the [Clinic] or wherever, I am not sure, I don't think they would be too thrilled. It's not like they would put me down for doing that, but it is such a strange thing to do. We're not familiar. Because I've seen things happen in my family where the victims, if I may call them that, they needed therapy. They need therapy. And therapy wasn't sought, or hasn't been sought. And it's the furthest thing from their mind. So I think the biggest hurdle they would have to jump over is the stigma. You know, you should be able to deal with your problems yourself.

Some (3) of the interview participants, chose to be selective about sharing information about therapy participation. Regina and Sarah explained that they decided not to share any more information with their family. Nadia stated that she chose to provide her mother with limited information. Nadia explained:

> My mother asked me today, do I still go to therapy, and she'll say "is it helping you?" and, "What do you all talk about?" and I say mostly… I don't tell her everything, I just tell her mostly I'm being educated on signs to look for and make sure I don't make those type of mistakes, the same type of men. I just let her think it's more educational than anything else.

Friends

Some (3) of the participants stated that their friends were aware of their participation in therapy. They found their friends to be supportive of therapy. Jeremy and Sarah explained that their friends were aware of and supportive of their therapy participation. Naomi explained that her friends knew, as well. Naomi recalled:

> But I have some friends who do not know. I have a close group of friends that do know. But I have not had a chance to tell everyone because it's just a process of having time to do it. And knowing that it's not just, oh by the way… It's a whole issue surrounding that scenario. It's kind of getting a lot of background of when it started or what prompted the situation. So I hadn't had a chance to tell them because it takes a lot out of me when I have to tell the story again.

Religious Beliefs

Several (4) of the interview participants described a strong connection to their church or religious beliefs. Nadia, in particular, discussed the importance of her religious practices during therapeutic treatment. Nadia recounted:

> Yes! Well, I pray a lot. I pray a lot, I read my scripture a lot and I've been working on myself religiously. I mean to improve myself, to be a submitter to God the way I believe I should.

Regina also explained:

> I believe that God will be in the midst of the therapy when we have therapy. He can put ideas into our heads as well as the therapist's head, I believe. So, yeah, I think it was a good going-together resolution.

Church

For most (7) of the participants, the church played a significant role in their lives. All of the interview participants reported attendance to a church or religious group gathering. However, some (3) of the interview participants explained that their church did not know that they were in therapy. Nadia said that her church did not know but she believed that they would have been supportive. On the other hand, some (3) of the interview participants reported that their churches were aware of their participation of therapy or their desire to seek therapy, Naomi, Regina, and David. Naomi explained that only some church members knew because she chose to be selective of whom she wanted to tell. Regina explained that counseling with the pastor did not help their situation, so they decided to seek other therapeutic services. She discussed their support of therapy. Regina stated:

> But I know that they pray for us, pray with us and they probably still praying for us. You know, I don't have no doubt about that. They even thought there wouldn't be nothing wrong with therapy. Because sometimes a minister or pastor cannot get all that information out of you, and a professional could, so they didn't have no hesitation to say therapist, there's nothing wrong with marriage counseling and may I should look at that, into that.

Many (5) of the interview participants denied that their religious affiliations made the process of therapy difficult. Only one participant, Edith, stated that if she had closer ties to her new church or was still connected to her last church seeking therapy would have been more difficult. Edith explained:

> Good question. Like I mentioned, I am not… maybe it would have been more difficult for me if I was that attached to my church quote, unquote yes. I think it would have been more difficult because then I would have more expectation. Saying OK, I can't handle this on my own, I would expect the church to be able to help me. But we're sort of unique, not in terms of special but unique in the sense that our circumstance at this time is this. We just moved here and, the attachment as far as cementing any relationships, we don't have that.

On the other hand, some (3) of the participants felt like their church or religious affiliation made the therapy process easier, and that their church and/or religious beliefs were supportive of it. Regina and David declared that their pastor and their pastor's wife

would be proud to know that they had sought and received therapeutic treatment. Naomi explained that her church members supported her by unobtrusively calling her to check on her progress. She recalled:

> Easier. Very much so, Because I'm very involved in my church. Not everyone in my church knows because I haven't talked. I've been selective. But those that do know in my church have been very supportive. And I was at church a couple of weeks ago and, I'm one of the choir directors there, and I was tired. I was overloaded. And one of them actually called and said, "Are you OK?" And I said, "Yeah, I'm just overloaded. I didn't like the session. My husband was being a jerk. I just decided that I was running too much and need to stop, so I did." And you know they were like, "OK, we just want to know you're OK and know we're here." And that's nice because they don't pry. Thy just constantly remind me to say that they are there if I need anything to let them know, and that's really sweet.

Expectations Regarding Therapy

Most (5) of the interview participants explained that they did not know what to expect to happen in therapy and were focused on the resolution of their presenting problems. However, after some thought, many of the participants had expectations for their therapist's function in therapy and the therapy setting. One participant discussed the therapist qualities that she expected from her therapist.

Lack of Knowledge

Some mentioned that reading or the media gave them some idea of therapy but they still remained ignorant of what the therapy process would entail. Sarah explained her own lack of knowledge of the therapy process. She stated:

> I don't know what I expected it to be. I don't know what I thought, what my expectations were um, I guess I had. I don't even know if I could say I had zero expectations because I really didn't know what to expect. I didn't know what the outcome was going to be.

One participant became more aware of therapy through academic studies in a class. Edith explained:

> I heard about therapy, but never used it before. What does it really involve? I've seen movies about the three faces of Eve, and that sort of thing, and saw it from the stuff I've learned in school which doesn't really tell me, I guess, because I'm not being trained for that.

Similarly, Jeremy's knowledge of therapy was influenced by film and media. Jeremy recalled: "I knew it would be awkward, I have seen the Sopranos quite often and knew what to expect. I had an idea of what to expect."

Focus on Problem Resolution

Some of the interview participants were focused on the purpose of therapy. They discussed their anticipation of being able to reduce conflict, renew trust, renew love, and improve communication. David discussed the changes he expected to see in his family as a result of therapeutic treatment. He explained:

> I expected to… from the time that we met, we be getting right back to that time where the trust is back, the feelings is back. The laughter, the fun, everything, all of that, is back to where we are now, with kids, to have a ball, to have a blast, just enjoying our life more.

Therapist Function

The participants expected a variety of roles of the therapist that would facilitate the amelioration of their problems. Those roles ranged from mediator, judge, supporter of parental role, facilitator of open discussion and "sounding board" or listener. Many (5) of the participants expected the therapist to provide direction or advice. Edith explained that although she was not sure of what to expect she still had thoughts of what she would have liked to happen in therapy. She recounted:

> But I wasn't sure if after, you know, I would tell my therapist my problem, and the therapist would say, "You know, I think this is the way you should handle this." I was kinda' sorta' looking for that. Somebody tell me what to do, you know? Sit there and wait until the day they turn 18, and the problem is out of your hands. They're on their own, or something. But I've also, based on what I've learned in the classroom, but I've also thought of maybe it will give me a chance to hear myself, speaking out, and the words will sort of bounce back on me and give me a chance to reflect on what I say. And so I thought about that, too. And the other thing I thought of was, maybe they would listen to me, listen to my daughter, and say, "See! Your mother is right! Listen to her!" Yeah, I wanted somebody to sort of, what's the word, back up what I was saying, because I want the best for my children.

Only one interview participant, Nadia, mentioned personal characteristics that she expected the therapist to possess. Nadia stated that she was concerned that the therapist

would not be genuine. However, she stated that she hoped that the therapist would be competent, caring, and concerned. Later, she said:

> I ended up kind of liking my therapist as a person. I didn't think I would do that. I really didn't. She seemed like a genuine person and I don't know. I didn't expect it. I just didn't know what to expect. But I didn't expect that.

Therapy Setting

Some (3) of the interview participants discussed what type of environment they expected therapy to provide. Edith said that she expected therapy to provide an unbiased atmosphere where she could express her feelings. Similarly, Nadia explained that she was looking for therapy to be a vehicle for self-expression. On the other hand, Jeremy expected to provide another type of setting. He stated:

> We tried ways, different couple's exercises. Except, one of the issues was that one of us doesn't listen when they are not in a controlled setting. Being in a room with a serious setting helped.

Pre-Treatment Concerns

The interview participants also expressed some concerns about receiving therapeutic services at a university clinic. Some (3) of the interview participants were concerned about the quality of service rendered at the university clinic. Some (3) also were concerned about the clinic's university affiliation.

Quality of Services

A couple of the interview participants were worried about the therapist's abilities and skills as a student. However, Edith explained that she was worried that the quality of therapeutic services would be based on how much she was able to pay. She also discussed concerns about being stigmatized for being a single-parent and a minority. Edith even mentioned that she was very concerned about confidentiality and who would have access to her therapy records. She explained these concerns. She recalled:

> Well, my thoughts on that was, 'I'm not a good parent,' that would be one conclusion that could be drawn from it, that I'm not a good parent. And you know, I'm just not capable of thinking on my own to solve my own problems. And the fact that the kind of society we live in, the American society, everything – the social security number, the credit cards,

everything follows you, once it goes down on paper. And I was afraid, like I said, I was in professional school, graduate school, so I'm afraid that sort of thing would follow me. That's a part of the stigma that it might seem like I'm not able to handle my affairs, so I was afraid of being stereotyped – low-income, Black, immigrant also, single parent, name all the minority stuff, we have it in this family. So all the things that go with the stereotyping, like I said, but most importantly, that once it goes down in writing, it will be there to haunt me. Somebody could dig it up and say, "Yeah, she's this kind of person." So yeah, it was difficult to reach out.

Clinic's University Affiliation

Some (3) participants expressed some "awkward" and "nervous" feelings associated with the clinic's affiliation with the university. Jeremy mentioned that it was awkward, while Sarah admitted that it made her nervous. Edith also discussed her feelings. She explained:

> I have to keep an open mind because I remember my situation at school. We use this sort of environment for learning; where patients come in, we get their consent, and you get that opportunity for learning. Whoever is in charge gets the opportunity to teach. So I'm sort of familiar with that. Was it attractive? Not really. But I was just trying to keep an open mind. This is the same medium that I use to learn.

However, most (5) explained that the clinic's university affiliation was "no bother." These participants were more concerned with the purpose of therapy and the practicalities of therapy, such as time availability and convenience.

Many (5) of the interview participants viewed their participation in therapy at a university-affiliated clinic positively. They were able to find an acceptable compromise. The participants explained that they were pleased to contribute to someone's education while they were receiving therapy. This included the participants, Anthony, Regina, and David. Even, Jeremy and Sarah, who said that they felt uncomfortable about the training emphasis of the university clinic, viewed the therapeutic relationship mutually beneficial. Sarah expounded:

> Well, I felt good that I was a part of something that was helping someone you know that part I enjoyed. They were there helping [therapist] become a good therapist and [therapist] was helping us to become a good couple, a better couple. So, I felt that that whole process was, was really good and I liked being a part of it.

University Clinic's Physical Surroundings and Services

The interview participants explained that they were satisfied with the university clinic's environment. They expressed that they had relatively no initial impressions of the building. The interview participants also explained that they were pleased with the waiting room. Most of their concerns were about the therapy room's training structure. In regard to the therapeutic services, the interview participants generally had positive impressions.

University Building

Most (6) of the interview participants explained that they were not affected by the physical attributes of the university clinic building. Many explained that it was "no bother" or there were "no impressions." Edith, however, stated that she appreciated the spacious building and that the size was not intimidating. Naomi said that the university-typed building was familiar to her; thus, she did not feel uncomfortable. Naomi said: "I just thought first it was a university and used to that kind of austere, functional, utilitarian kind of look. And so it didn't bother me one way or the other."

Waiting Room

Most (5) of the interview participants described the physical environment of the university clinic waiting area as "comfortable," "inviting," or "relaxing." They explained that the availability of a couch, reading material, and children's play items contributed to the comfort of the waiting area. Specifically, Naomi explained that it was "okay," not uninviting but not real warm. Sarah and David stated that it was familiar; it reminded them of a doctor's office. Sarah said:

> I really didn't give this building too much thought but walking into the
> office I felt that it was inviting because you had you know the couches
> there and the um children's stuff so I didn't feel threatened by that. Yeah,
> I thought it was comforting. You know it was just something familiar,
> you know, it wasn't, it was familiar to me, almost like a Dr.'s office.

Particularly, the interview participants discussed their satisfaction with having books and magazines available to read. Naomi said: "I could find something to read. I wouldn't have had to bring my own. So that was good."

Most (6) of the interview participants also explained that that they were impressed with the waiting room's child and family orientation. Some said that they were surprised to see the toys and the train set. Regina remarked:

> Well, I was impressed they had something for kids, that you could bring your kids. I didn't know we could bring our kids, we had time to get the babysitter that night, but that's the first things I saw… there was things for the kids. But other than that, it was fine.

Therapy Room

Most (6) of the interview participants expressed some level of discomfort with the training equipment, which includes a one-way-mirror, video camera, and phone in the therapy room. Some (3) of the participants, Jeremy, Sarah and Nadia, explained that the equipment was distracting or "hard to ignore." Two of the participants, Edith and Nadia, also pointed out that the therapy room "lacked privacy" with the use of the one-way mirror, video camera, and the phone. Edith was the only participant to later request that the video camera be removed. Sarah explained her disappointment with the training system. She said:

> We started the sessions, and we would get into a situation and the phone would ring and we would have to stop what we were doing and [the therapist] would have to answer the telephone and have a conversation with the people behind the glass. And then you know I felt like well, why don't they just come in here and talk in here rather than out there? It was like the phone would ring and it was like ok I guess God's calling you know and it's like, 'uh huh, uh huh, uh huh, ok, bye.'

> So, it was uncomfortable because then I had to stop. A few times we were really into a, a discussion, almost like a confrontation and then it would stop and we'd have to go do phone call and then you know we were redirected to something else you know and that felt like we weren't able to finish some things. So, that was a disappointment.

Several (4) of the participants, however, were also able to view the use of the training equipment positively. Although expressing some concerns previously, Edith and Sarah were able to see the educational purpose for the use of the equipment. Jeremy remarked that it was "inventive." David explained that he did not have any problems

with the training equipment because he was more concerned with the therapy process. He said:

> It was fine; it was good to see the camera there. I seen it when we went. I was telling her, they looking at us there, right there, where the window at or whatever. It was no problem. I just sat back and talked, talked about our life. We're here for one reason – to bring us back together.

Therapeutic Services

Overall, all of the interview participants reported that they had a positive experience at the university clinic. The participants explained that they liked their therapists, found therapy to be helpful, and that they were satisfied with their treatment at the university clinic. They also noted that they did not experience negative differential treatment. The interview participants described their experience as "positive," "good," and "pleasurable." Regina seemed to sum up what many of the other participants experienced. She explained: "It was no negative things, it was polite, helpful, patient, understanding. Nobody trying to give you a runaround or have you feel that you're nothing, or anything like that. It was all positive."

Several (4) of the interview participants talked about what qualities they liked about their therapist. Sarah described her therapist as "nice" and "open." Edith said that her therapist was "quiet" and she explained that their "spirits meshed." Naomi talked about the positive characteristics of her therapist. She said: "She's been very good. She's been attentive to me in particular, which has been very nice - understanding. And I think that her way about doing this is very gentle, very calm, non-threatening, has been very helpful."

Several (4) of the participants also explained that they had not experienced any differential treatment at the university clinic. Jeremy replied: "I didn't find anything different. You know there are things in life that are different because you are a minority, but this was not like that for me, which was cool." Similarly, Anthony remarked: "I don't think they treated me any different. I am a case. I don't feel any different. Being a Black man in America is not easy, but I also made it difficult for myself."

Three of the interview participants also discussed whether or not they felt like a minority in the university clinic or felt different from other clients at the clinic, in regard to their race/ethnicity. Two of the participants said that they did not feel different. Edith stated:

> Well, ethnicity came in the picture when I am in the waiting room and I see Caucasians and I see Hispanic families walking out. It just made me feel like an ordinary person. That Caucasian people use the service, Hispanics use the service, and here I am as a, you know, Black family. I don't recall seeing males, whether they be boyfriends, husbands, dads, but I saw women with kids. So I can't say anything as far as the gender is concerned. But it made me not color things, or add any conditions as far as ethnicity is concerned because I saw other people using it so that kind of took that away from me, despite my feelings, you know, issues like that. It helped. It made me less afraid. Or let's say it made me not feel too different, you feel normal.

On the other hand, Nadia had a different experience. She explained:

W: Yeah it would have been nice if I had seen some Black pictures. Actually … I don't think I've seen a Black person since I've been there. I don't even believe I've seen a Spanish, I maybe, I just mostly see Caucasians.

I: So how did that make you feel?

W: It just made me feel … stand out. I didn't see no other people like me.

I: Do you think it would be more comfortable if you saw another Black family around? Do you think that would make you feel more comfortable?

W: Yeah I guess it would have.

I: Well that's the end of the second part unless you have anything to add?

W: Oh the other thing is that I overcame all of that. I knew I was a minority and I managed to relax and try to get as much out of the therapy as I could.

However, many (5) of the interview participants also experienced the therapeutic services as "helpful." The interview participants felt like that they received a sufficient amount of help. Anthony said:

> Yes it was helpful. I wanted to stop doing all of the bad stuff. I have a lot of issues I want to resolve… So therapy was able to help me get through

get past a lot, helped me get myself back together because I want to be a good person and it is happening now in therapy.

There was only one participant that expressed concern about how a certain therapy situation had been handled by a university clinic staff member. The participant explained that a university clinic staff member made a choice to communicate certain family behavior to local state representatives and that she was not given a reasonable explanation of the basis for the decision. The participant also explained that the staff member had been "cold" and did not try to understand the situation, fully. Yet, overall, the participant explained that therapy had been helpful and that they were satisfied with the therapist; however, the participant was not sure if the handling of the therapy situation was related to race or socioeconomic status. She explained:

> I don't know if it's my race or the economic status. I don't know. Cause like I said I saw other people. But then I don't know their individual session, the quality, what happened. But personally I have doubts as to why the [staff member] would have responded that way. I just have doubts as to why [the staff member] responded the way [the staff member] did.

Therapy Expectations

Some (3) of the interview participants experienced the therapy as being different from their expectations. They explained that it lacked certain aspects. Nadia explained that the therapist talked less than she expected and provided less information. Sarah and Jeremy said that the therapist did not act as a judge for their couple concerns as they initially hoped. Jeremy added that his therapist provided less direction than expected. Jeremy and Nadia also stated that therapist performed in ways that they did not expect. Jeremy said his therapist facilitated more communication than presumed, while Nadia said that she did not expect her therapist to ask as many questions as she did. Jeremy explained:

> We spent a lot of time talking and listening. We were looking for more of a direction than we found. We needed the direction. We started therapy to find out who was right and who was wrong. That doesn't happen. We finally gave up on that belief and everything started to fall into place.

Importance of Therapist Race

Most of the interview participants explained that therapist qualities such as competence, skills, genuineness, and care were more important than therapist race. While some participants initially hoped to have a Black therapist, most did not have a preference for a Black therapist. Despite this, the interview participants explained that there were some benefits to having a Black therapist.

Priority of Therapist Competence over Therapist Race

A couple of the interview participants, Sarah and Nadia, said that they had initially hoped to be assigned a Black therapist. However, they explained that they were satisfied with their current non-Black therapist. Nadia explained:

> Yeah. I don't know I guess I didn't think I was going to have an African American therapist. I was kind of hoping I would. I didn't and then the other thing was I hoped that I would like my therapist and when I did that was good.

On the other hand, most (6) of the interview participants said that they did not have a preference for a Black therapist. Several (4) of the interview participants explained that race of the therapist did "not matter." They believed that therapist skills and knowledge were more important. Naomi stated that therapist knowledge of a client's culture was important and that a therapist of any racial/ethnic background could find information of different cultures. Edith and Nadia said that therapist qualities such as being empathetic, "genuine," and "caring" were more important than race. David also believed that competence was more important. He said:

> I mean I would feel more comfortable with whomever if he's qualified to be in a position that they are in to help. It doesn't matter to me to race. It's all about are you qualified to, to me and my wife, to help me, to get through what I need to get through. We can still have fun in different ways or our own ways. It wouldn't matter to me.

Similarly, Edith said:

> It is said that people relate to their kind better but people tend to, the kind of people…and I'm not stereotyping or labeling or … but I find that people who stick to that are the uneducated people who are just not aware of what's out there. That they feel like only a Black man can understand another Black man's problem. True he has insight based on experience but it doesn't necessarily mean he's the best person because people are

learning about other cultures. We are a multicultural society now and people can be understanding, not necessarily understanding the details of the culture but dealing with people on a humane basis you know. You know, wear the other shoe sort of thing, empathetic and so on. That can go a long way, even more than having insight on a culture. It can go a long way.

Several (4) of the interview participants discussed the significance of race in their therapeutic experience or their personal perceptions on their race. Two of the participants, Sarah and Naomi, explained that their therapy experience was not race-related but more culture-related since their husbands were of different cultures. Two participants, Anthony and Edith, explained that they did not take race into consideration, due to their beliefs about race. Anthony explained his perceptions of race and therapy. He said: "You know I don't even think of myself as being a Black person, but as a person. I really don't view it like that. I don't think of people looking at me differently." Edith added:

> That's a good question, it is. Because I've heard … personally I try not to color things. I try to see things for what they're worth or see things as they are. I mean, you know, the reality. But I have heard that …psychosocially, Black people would have been better off if they had access to the service that the [Clinic] provides like White people. I've heard that. Personally…like I said…I don't know. I try not to color things, but yes, we're in a society where color, economic status determines what you have access to. And therapy is good. Then again, my opinion is that people would want to turn to what they feel they can trust first. People close to them, family, church, and maybe a stranger if they will listen. But I wasn't even thinking of my ethnicity. My biggest concern was the quality of service, if it would match my status. What you pay for is what you get. That's what I was afraid of. Or should I say one of the things I was afraid of or concerned about.

Benefits of a Black Therapist

Although most of the interview participants did not prefer a Black therapist, many (5) of the interview participants, when asked, reported that having a Black therapist would have benefits to the therapeutic relationship. They believed that Black therapists may have better knowledge of their Black culture, which would be advantageous to the therapist-client relationship. Naomi talked about how a non-Black therapist may lack knowledge of Black culture. Naomi explained:

Because I do think unless they counsel a lot of Blacks. I think each culture has unique character. I don't want to say characteristics because I'm not only talking about people, but unique traditions. And it's not that they wouldn't be able to know what those traditions are, but they would have to have exposure to them. But the cultures are very different and it takes time to really research the culture so you know how people respond to certain things and act a certain way.

Two of the participants, Regina and Nadia, also discussed how having a Black therapist may increase their comfort in the therapy sessions. They both stated that they would probably be more open and expressive with a Black therapist. Nadia also added that she expected a Black therapist to have certain qualities. She explained:

Actually I don't think it would have been much different but I kind, before I got started with my therapy, I kind of felt like I could be open more with Black American therapists and I felt like a Black American therapist would have been more genuine and had more compassion and understanding of being a Black American their self. As it turned out I … I don't know how many times it took till I got comfortable with my therapist, but it didn't seem like it took that long.

Several (4) of the interview participants indicated that a Black therapist might be helpful for certain types of problems. Sarah and Jeremy said that it would be helpful for "race-related issue" or "ethnic issues." They did not specify what they meant by these terms. Naomi said that having a Black therapist might be helpful for an inter-cultural couple having communication problems. Regina explained that it might be beneficial in family counseling. She explained:

Like the example I gave before with my brother, like bringing a third party in. If he had to go to a therapist I think he would have to go to a Black, African American therapist. And he probably would want a guy. Because of the fact of again, a similarity there. He feel he could probably be more confident to talk about what actually could not talk about before to his wife or to another person. I think maybe it would be more beneficial for him because of the fact that it is a black therapist; it is a Black man talking to him. Sometimes, having an African American in different situations as far as the family can help. Because everybody not gonna know what the therapist like. I'm sure that person in touch some kind of way with what you're doing. So that person have that similarity there so that guy can bring a lot more to the table than someone who is not that culture.

Decisions Regarding Treatment Continuation

All of the expressed their satisfaction of therapeutic services received at the university clinic. They explained that any decisions to discontinue services were not based on a negative therapeutic experience and their reasons for staying were based on a positive experience. Many of the participants were also influenced to stay or discontinue because of other factors outside of therapy that they had to consider, such as finances, time availability, and childcare. However, they also decided to continue or discontinue based on the expectations of relationships with significant other or between family members.

Continuing

Some (4) of the participants remained in therapy. Jeremy said that he was "happy" with the therapy that he received because he addressed his presenting concerns. Naomi explained that she was finding the therapy to be beneficial because there was an increase in couple communication. Naomi explained her reasons. She said:

> Well it' not that I'm court ordered because I can end it now if I wanted to. But I also think there's some value for my husband hearing me. And I think the only time he hears me is when we're in therapy here. And so I think there is value in that. And that he is forced to sit still long enough to communicate with me and also for me to communicate with him. And issues that he would not discuss otherwise he's being forced to not dismiss. He has to discuss them. We have to work through these things and he may not be doing it willingly but he has to. And I think there is value in that. Because that does force him to listen and not run off. So that's why I would stay.

Naomi also explained that she decided to remain in therapy because she wants her daughter to have a better relationship with her father. But, Sarah discussed how feasible it was to continue therapy at the university clinic. She said that price, flexible times, and childcare reasons also influenced her decision. Sarah stated: "I guess because I saw a positive outcome. The price was good for us, the schedule was flexible, and it was helpful that I could bring our child with us."

Discontinuing

Some (4) of the interview participants decided to discontinue treatment. Regina and David believed that the therapeutic service that they received was "good." Edith explained that she was "forced" by the staff to make a decision and so she chose to discontinue. But, she also felt like her family had made some progress and had gotten through the initial crisis. Edith talked about her decision. She said:

> And I was making improvements. And I understand the center's standpoint but I was kind of sort of forced to make a decision cause I was told, "Well, you're not coming here every week and somebody else needs us. We're moving on." You know, time to make a decision. And I decided. You know with the amount of improvement we had maybe I should.

Several (4) of the interview participants mentioned practical reasons for discontinuing therapeutic services. A few (3) of the participants were having conflict with time, such as coordinating childcare and kids' activities with the university clinic's schedule. Edith said that the driving distance from her home to the university clinic was too far. Regina explained childcare availability was a concern for family. Nadia explained that she wanted to use her money for other things since she was confident that she no longer needed therapeutic services. Regina explained:

> We would still be going there if transportation was right and the timing was right. Those two things were our downfall. Not more of the transportation, I think more of the time. Morning time is better for us than the evening time. So that was the main issue of how we discontinued it. It's not to be discontinued because our service wasn't good. It messed up our babysitting. Our kids had activities at the same time.

One participant explained that a change in his relationship with his partner was the impetus for their decision to discontinue therapeutic services at the university clinic. Jeremy explained that he and his partner separated while they were in therapy; thus, they felt that they no longer needed couples therapy. Jeremy said: "It wasn't a reflection on the therapy. We got to a point in therapy to communicate that we did not want to be together… Therapy was based on working on the relationship."

The interview participants were asked to discuss what they wanted to be different in their experience at the university clinic. Although generally satisfied with services at the university clinic, the interview participants had some important ideas. Several (4) of the interview participants listed changes that they believe would be helpful for the university clinic structure, physical surroundings, as well as therapeutic services.

University Clinic Structure/Service Delivery

Some (3) of the interview participants were concerned about service availability. They preferred to have more times available during the day or on the weekend. Also, Jeremy remarked that he would have liked the sessions to be longer because he did not feel like they were able to make as much progress in an hour. Regina and David explained what they would have liked to have more morning times available. Edith had a few recommended changes. She desired that there was more information about what to expect from therapy and during therapy and that there were clear directions in the waiting room. Edith discussed her desire more information about therapy. She explained:

> At my first session I was asked the appropriate question "Why are you here?" I explained that but, maybe they could have gone a little bit more into explaining what exactly that the therapy would have been about, what they would have provided. If they would just listen you know, say we can… we will provide this forum where you can speak. The information will be kept confidential. But this is what we can do. We can only listen. Or, we'll listen and if we feel like you are doing something wrong we'll indicate it to you or whatever. That sort of thing was left out.

Physical Surroundings

Although generally satisfied with the waiting room's comfort, several (4) of the interview participants explained that a few changes, however, would facilitate greater warmth, comfort, and invitation in the waiting area. One participant, Nadia, suggested pictures with Black people on them. Nadia said:

> I was thinking about something like the pictures or the scenery like putting up more black pictures but I don't think they put pictures in those rooms anyway. I guess they just want you to concentrate, I mean you know, not to focus on any other thing except why you are there. But it might be helpful to have some more pictures of African Americans in the pictures.

Two of the participants, David and Nadia, explained that although there was one good chair that was more beneficial to their back health, the chairs were too low. Nadia remarked:

> I guess I would like, I would have liked the chairs to be a little more comfortable. First of all they set too low for me. They weren't that comfortable. There was one chair that set against the wall that was a good chair, but you couldn't always get that chair.

Two of the participants, Sarah and Edith, were dissatisfied with the lack of direction in the waiting area. They suggested a receptionist or a sign to instruct clients what to do and where to go when they arrive. Edith explained:

> When we got there we went in there was no one and no signs to say this way to sign in, or go to this room and let this person know you're here or whatever. We walked around, circled the whole area, not knowing what to do. No one was there to direct us, no signs, nothing. Eventually we knocked on a couple of doors. Someone came out and we said can you tell so and so we're here… I just kind of felt it would have been much smoother if someone would have been there to direct us.

Advice for MFTs Working with Black Clients

The interview participants also presented advice for therapists to consider when working with Black clients. Three of the participants, Regina, David, and Edith, discussed how they believed that a therapist should present himself or herself. David suggested that the therapist be genuine and open. Regina suggested that the therapist create a comfortable atmosphere by empathizing and normalizing. Similarly, Edith asked that the therapist promote an unbiased atmosphere. Edith explained:

> My advice would be that people sort of expect to be stereotyped because that's the society they're in. People are partial. And so I think they should do whatever to somehow squelch that; that you know the service is not dependent on your status. I mean you have agreed to provide on a sliding scale. So, aside from say advertising that, but promote an atmosphere where you know you feel like it doesn't matter. Maybe the way you react to what you hear, like that [staff member] did, you know? His response made me want to think is there some kind of stereotype or something? What made him react that way? Instead of trying to be understanding, to say well this is your situation. Yeah he did tell me, yes we have an obligation. It could have been handled differently I think.

Several (4) of the interview participants also suggested that when working with Black clients that the therapist actively facilitate problem resolution. Edith suggested that the therapist provide explanations for actions taken in therapy. Naomi suggested teaching conflict-resolution skills. Regina offered that the therapist gives advice. David offered that he/she asks questions, give feedback, and get straight to the point. He explained:

> Down to earth and just be, be open about it, you know, ask questions, ask it and respond back, give feedback on it. It should be, you know… Just be yourself. Like you're at home or whatever, you be yourself, you can be there, be yourself, open. Hey, what can I ask [client name] next? How did this get to this point? And what made it to this point? That's it. Just be real and get straight to the point.

There was one interview participant that had suggestions for the kind of knowledge and skills a therapist should possess. Naomi suggested the therapist understand the cultural background of the client, possess listening skills, and have the ability to teach. She explained:

> That's a very good question. The listening skill is very important, the ability to teach, agreeing…, disagreeing with, how to disagree that doesn't destroy the relationship. Agreeing to disagree… And I think, I hate to think that's the case, but ethnicity does play in a lot. The traditions and backgrounds of cultures really play in to how people come together in a familiar environment and react with each other. And I keep thinking a lot of this digging in the trenches has to do with his [husband] cultural background even though his father is not like that. It's still part of the cultural background for him. And I think that understanding these cultural backgrounds, particularly with interracial couples will help to be able to whittle away some of the stuff that is going on.

Summary

While there were some exceptions, most of the interview participants thought it was not acceptable or normal for Blacks to seek therapy. Many participants talked about their beliefs, their family's beliefs, and the Black community's belief that Black people should solve their own problems, rather than go to a therapist. Despite these initial negative preconceived ideas of therapy, the interview participants found the courage to seek therapy. They were determined to protect their families and relationships.

Although exercising some caution with disclosure, the interview participants relied greatly on their family, friends, and church/religious beliefs. Many found support from family, friends, and church members. No one believed that their religious beliefs or church beliefs hindered their participation in therapy. Family, friends, and the church were a source of support before and during the interview participants' therapy experience.

When considering the option of having a Black therapist, the pervasive view of the participants was that it is more important for a therapist to be competent, skilled, genuine, and caring than be same-race. It is important to note here that the two interview participants that initially preferred a Black therapist also scored the highest on the Centrality scale and the Minority and National Ideology scales. However, these two participants later explained that they were satisfied with their therapist, despite therapist race.

However, many of the interview participants added that having a Black therapist has benefits for a Black client. They explained that a Black therapist would facilitate more ease, comfort, and openness in a therapy session. They thought that Black therapist would be more familiar with their culture and background.

Generally, all of the interview participants reported a positive experience at the university clinic, with the exception of the one negative incident mentioned earlier. Even with this concern, the interview participant also had positive things to say. The particular participant and others explained that they liked their therapist and that they perceived the therapeutic service to be beneficial. No one discontinued therapy because they had been unhappy with therapy.

Finally, the interview participants offered suggestions to the university clinic to facilitate client satisfaction, despite their general satisfaction of the university clinic environment and services. They also advised marriage and family therapists that work with Black clients to take an active and directive approach in the therapy sessions, as well as to possess cultural understanding. In conclusion, Regina had one last piece of advice, in regard to the university clinic:

> Well, it's [family therapy clinic] a good thing. A lot of people don't know
> about it. It needs to be more broadcast. It seems that more, something
> that's good is sometimes put undercover. So it need to be more exposed,

so other people can know about it, so other people can take advantage of what they have to offer.

CHAPTER FIVE: DISCUSSION

Introduction

I examined the experience of Black clients at a university clinic, using quantitative and qualitative measures. First, I gathered demographic data and data about the experience of therapy sessions by clients at the university clinic, especially Black and White clients. Then, I used face-to-face interviews to examine the experience of eight Black clients in marriage and family therapy at the university clinic. Below, I will summarize and discuss the findings of this study. Then, I will discuss the limitations of this study. Finally, I will present implications for future research and clinical practice.

Summary of the Findings

Black and White Clients

The findings of this study suggest that the Black and White clients at the university clinic are similar. There were not any significant differences in treatment length. In other words, Black clients did not attend more or less sessions than White clients, or vice versa. This is not consistent with research literature, which suggests that Black Americans attend fewer sessions than White Americans and other groups. Sue, et al. (1991) reported that Black clients attended on average 4 sessions, while White clients and Hispanic clients attended on average 5 sessions and Asian clients attended 6 sessions, on average.

Furthermore, Black clients and White clients also had similar drop out rates. This also contradicts the research literature. According to Bischoff and Sprenkle (1993), most marriage and family therapy research literature reports that Black Americans drop out of therapy more often than do White Americans. Additionally, Hu, et al. (1991) conducted a ten-year review of public mental health service and found that Black Americans dropped from therapy after the first session more often than White Americans. However, the finding is consistent with results reported by O'Sullivan, et al. (1991) who stated that Black Americans did not have a higher drop out rate than White Americans. Thus, both of these findings support Neighbors, et al. (1992) who suggests that more research is reporting that there are not significant differences in Black and White American treatment length. However, lack of difference in drop out between Black and White

American clients found in this study may be more reflective of the fact that most Black clients in this study were middle-income clients. Viale-Val, et al. (1984; cited in Bischoff & Sprenkle) found socioeconomic to be more indicative of drop out for Black and White Americans than was race.

The findings of this study also suggest some ways that Black clients differ from White clients at the university clinic. Despite similarity in educational attainment, the Black clients reported lower income levels. Snowden (2001) reports that a higher percentage of Black Americans than White Americans are below the poverty line which may explain this finding. The low-income level of the Black clients lends support to the documentation that Black Americans experience employment discrimination and are economically marginalized (Bowman, 1993; Henriques, 1995).

Black clients were also significantly younger than the White Clients, with ages primarily in the 30s. Literature suggests that younger Black Americans are more receptive to therapy. Jackson, et al. (1986), based on a national survey of Black households, reported that younger Black Americans were more likely to seek professional help for emotional problems than were older Black Americans. Some of the interview participants suggested that increased awareness in the public through the media and increased education of Black Americans has contributed to a new generation of Black Americans that are more receptive of therapy.

Black and White clients also experienced the first session of therapy differently. Black clients perceived less depth in the session. According to Stiles, et al. (1988), sessions that differ by counseling style are experienced differently. Stiles, et al. (1988), using as earlier version of the SEQ (the instrument used in this study), found that therapy more exploratory in nature was not perceived by clients (race unknown) as deeper or as more powerful and valuable than a cognitive-behavioral style. Thus, the Black clients may have experienced a difference in therapist style.

The literature reviewed suggests that Black American clients prefer a more active or directive counseling style (Bean, et al., 2002; Kurilla, 1998; Okonji, et al., 1996). The Black clients may have expected the therapy sessions to be more activity or direction-oriented, which the interview participants discussed in the interviews. Also, the university clinic generally espouses a more strengths-based approach to therapy. The

black clients may have desired to address their concerns more quickly than they were addressed in the first session which may have led them to perceive the session as less deep than the White clients perceived their first session. Or, the finding that Black clients perceive the session as less deep could suggest that the therapists took more time to join with the Black clients before they get into more intense discussion, possibly due to less experience with Black clients.

Also, Black clients that remained in therapy at the university clinic experienced less smoothness or relaxation and comfort during the first session than the Black clients that dropped from therapy. Stiles, et al. (1988), using an earlier version of the SEQ, reported that clients perceived a cognitive-behavioral style of therapy as smoother than an exploratory style of counseling. The exploratory style of counseling was also perceived by the clients to be rougher, or as causing feelings of sadness, fear, anger, and uncertainty. It may be possible that the Black clients that remained in therapy perceived that there was more work being done in the first session than the Black clients that dropped from therapy. This would add support to Gregory and Leslie's (1996) suggestion that a decrease in smoothness over time for the clients in their study was related to the hard work of therapy.

In addition, the Black clients that remained in therapy may have had more serious presenting problems; thus, accounting for the lower smoothness in the first session and their continuation in therapy. Several of the interview participants indicated that they came to therapy in "crisis" and focused on problem resolution, and had been referred to therapy by an outside agency. This provides some support for the literatures which reports that many Blacks enter the mental health system after a crisis and when the need is identified by community agencies, resulting in more court-orders and referrals for Black Americans (Boyd-Franklin, 1989; Redfearn, 2003).

Interview Participants

Sample Description Similarities

Many of the interview participants were middle income and most had some college experience. There were only a few interview participants that considered themselves to be of low socioeconomic status. This may be a reflection of the regional location of the university clinic, which is predominately White, high income, and values

education. According to the U. S. Census Bureau (2001), the median household income for the region is $81,050.00.

Many of the interview participants lacked experience and knowledge of therapy. There were only a few interview participants that had some previous therapy experience. This is consistent with the literature which explains that Black Americans traditionally do not seek therapy (Surgeon General, 1999). Neighbors (1985) reported that in a national household survey of Black Americans, most of the survey respondents were not inclined to seek help from mental health professionals, despite the need. Most of these interview participants were middle-income couples. This supports the literature which explains that middle-income Black couples are more likely to seek treatment (Boyd-Franklin, 1989; Ho, 1987).

Interview Findings

Many of the interview participants discussed the Black community's view of seeking therapeutic services as unacceptable and abnormal. One participant explained that Black Americans view therapy as something that White Americans predominately use. This supports the literature. Boyd-Franklin (1995) stated that Blacks make a distinction between Black American and White American use of therapy. According to Boyd-Franklin (1995), Black Americans tend to view therapy as an enterprise for White Americans. Specifically, others in the literature have explained that Black Americans do not trust the mental health system because it is considered to be a White, middle-class institution (Leong, 2001; Surgeon General, 1999). Cooper-Patrick, et al. (1999), in an interview of Blacks and Whites in the Baltimore National Institute of Mental Health Epidemiologic Catchment Study, found that the Black American participants were more embarrassed about seeking mental health treatment than White American participants, after controlling for age, educational level, and having a consistent source of healthcare. Some of the interview participants also associated seeking therapeutic services as a service for "crazy people." This is also supports the findings of Ho (1987) and Boyd-Franklin (1989), who stated that some Black Americans perceived therapy to be strange and for crazy people.

Many of the interview participants explained that seeking therapy is a sign of personal weakness because Black Americans are expected to solve their own problems or

persevere in the midst of their problems. This is consistent with the literature. Ho (1987) affirms that Black Americans tend to value the endurance of suffering due to a history of adversity faced by many Black Americans. According to Leong (2001), this type of coping has been labeled, "John Henryism."

Family was also perceived by many of the interview participants to be very important. For most of the interview participants, the desire to protect family and couple relationships was a motivating factor for seeking therapy, despite knowledge of the stigma of therapy in the Black community. All of the participants were parents and many were married, presenting with relational concerns. This is consistent with the literature. According to Hill (1993) and Ho (1987), strong kinship bonds are important to Black Americans. It seemed that the interview participants were willing to go to great lengths and exceed personal and cultural comfort zones to keep their families and couple relationships strong and in tact.

Many of the participants relied on family and friends for support and advice before therapy. This finding supports the reports of several professionals in the literature (Fischer & Shaw, 1999; Franklin, 1993; Neighbors, et al., 1992; Wilson & Stith, 1991). They suggested that many Black Americans prefer to seek family, friends, and the church before seeking non-traditional help. Yet, the interview participants eventually sought therapeutic services. Snowden (1998) suggested that members of the traditional support network help Black Americans recognize the need for professional help. The findings of this study provided support for this theory. Some of the interview participants explained that a friend or family member suggested therapy as a resource, which helped them to decide to initiate services at the university clinic.

Despite being aware of negative perceptions of therapy, these interview participants sought therapeutic services. This finding supports the literature. Hines and Boyd-Franklin (1996) explained that Black Americans are seeking therapy in increasing numbers. Specifically, they have been using mental health services in greater numbers since the 1960's (Ho, 1987; Neighbors, et al, 1992; O'Sullivan, et al., 1989; Zhang & Snowden, 1999). These interview participants may have been more open to seeking therapy due to their racial identity status. Based on the results of the MIBI (Multidimensional Inventory of Black Identity), the interview participants generally

espoused more humanist and assimilation views. This means that the interview participants believed that the common characteristics with being human were more important that similarities based on characteristics such as race, gender, and class. As well, they espoused the idea that idea that Blacks should assimilate into the mainstream society in the United States.

While some of the participants reported that their family, friends, and church members were supportive enough of therapy to suggest as an option for problem resolution, there were some interview participants that found members of their support network to react negatively to their disclosure of the therapy process. The interview participants that received more positive responses sought more support of family, friends, and church members during their participation in therapy. The interview participants that received a negative response from family and friends were more cautious about discussing the therapy process to these traditional supports. This is similar to Snowden's (1998) finding that Black Americans were less likely to seek help from the traditional support network when there were mental health problems, as well as Jackson, et al.'s (1986) similar finding that they are less likely to disclose emotional problems. One participant, Nadia, explained that she anticipated that her mother would have the same negative view as others, so she limited the information she gave her mother about participation in therapy. Although these interview participants sought support from family, friends, and the church, some of these participants did not perceive support from these supports, due to their negative perceptions of the therapy process.

Although all the interview participants reported church affiliations, only one couple sought help from the church pastor before seeking mental health treatment, even though some explained that they would have sought help from their pastor if their situations were different. However, this finding seems to question the level of importance or feasibility of the pastor as a mental health resource for Black Americans prior to seeking therapy, which was noted in the literature (Fischer & Shaw, 1999; Franklin, 1993; Neighbors, et al., 1992; Wilson & Stith, 1991). Neighbors (1985) reported that Black Americans seek help from pastors more often that seeking professional help. However, some of the interview participants did not feel connected to their pastor or were concerned about their confidentiality being protected.

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All of the interview participants acknowledged attending a church or mosque. Although a few of the interview participants mentioned that there were beliefs that Blacks should pray to solve their problems, many of the interview participants did not report experiencing their religious beliefs or church involvement to interfere with their participation in therapy. In fact, the majority believed that these made their participation in an easier process. Most perceived support from their church members and religious beliefs. For some, religious practice and support, such as prayer, seemed to complement the goals of therapy. This result seems to contradict the suggestion that religious beliefs may hinder Black Americans seeking therapy (Ho, 1987) or facilitate the perception that therapy is indicative of a lack of personal trust in God (Boyd-Franklin, 1995). However, the results of this study lend support for the findings that many Black Americans are members of a church and believe in the practice of prayer (Taylor, 1988; cited in Hill, 1993).

Most of the interview participants did not prefer a Black therapist and race of the therapist was not important enough to the participants to precipitate early termination. This is not consistent with most of the literature in the field, which indicates that Black Americans prefer Black therapists to non-Black therapists (Neighbors, et al., 1992; Okonji, et al., 1996; Snowden & Hu, 1996). Some researchers in the field also found that ethnic mismatch of therapist-client dyads resulted in early termination of service or lower service utilization (Snowden & Hu, 1996; Yeh, et al., 1994). Thus, it seems important to recognize the diversity of beliefs and experiences within the Black community. This finding could be due to the geographical region that these interview participants live in, which is diverse and highly educated, and due to middle class values of the participants.

The findings of this study and the conflicting results of other studies suggest that there may be important differences among Black clientele that has not been considered. There are important differences between the participants of this study and the participants of the studies cited above. For instance, Okonji, et al.'s (1996) sample was primarily low-income individuals and Yeh, et al.'s (1994) participants were adolescents. Most of the current interview participants were middle-income and in their 30's. The interview participants of this study are different from the participants of other studies by age and developmental level, socioeconomic status, and possible presenting problems.

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This study also found that only two of the interview participants initially preferred a Black therapist. These two interview participants also scored the highest, among the interview participants, on the Centrality scale and the Nationalist and Minority Ideology subscales of the Multidimensional Inventory of Black Identity. This means that these two interview participants' race was more central to their self identity, that they believed that Blacks should associate often with other Blacks, and that they were more concerned with the oppression of all minorities than the other six interview participants. The interview participants who did not have a preference espoused more humanist and assimilation views. This study's finding for therapist preference is consistent with some literature that suggests that client racial identity and values are strong predictors of client's preference for therapist race/ethnicity (Helms, 1984; cited in Gary & Kaplan, 2000; Morten and Atkinson, 1983; Terrell & Terrell, 1984). Helms (1984; cited in Gary & Kaplan, 2000) found that clients with attitudes toward their own race and other groups that are similar to those of the dominant society are less likely to prefer a same-race therapist. Using Minority Identity Development (MID) model, Morten and Atkinson (1983), in a survey of Black college students, found that the majority of the students that espoused minority values versus values of the dominant society preferred a Black American therapist to a White American therapist. Similar to the findings of this thesis, the students that espoused values closer to the dominant society did not have a preference. These results suggest that Black American clients vary in values and preference for therapist-race. Thus, clinicians should not assume that Blacks clients prefer a same-race therapist or that they do not have a preference for therapist-race.

The results of this study add further support for the importance of racial identity in the evaluation of Black American experiences in marriage and family therapy. Other researchers have also found that racial identity influences perceptions of the therapist and therapy (Helms, 1984; cited in Gary & Kaplan, 2000; Morten & Atkinson, 1983). Based on the results of this study and others, Black Americans vary in racial identity.

Although two of the interview participants initially preferred a Black therapist, these participants reported that they were satisfied with their current therapist and that the therapist race was less important. This supports some literature in the field. According to Gary and Kaplan (2000), many Black clients that initially preferred a Black therapist

reported that they would return to their non-Black therapist, if they were given the option to have a Black or non-Black therapist. Also, Gregory and Leslie (1996) found that racial composition of the therapist-client dyad had little effect on the outcome of Black American clients that remained in therapy. Most of the current interview participants were more concerned about the skill, knowledge, and warmth of the therapist than with their race. This finding is consistent with literature in the field which suggests that such variables as therapist competence (Ho, 1987), warmth and genuineness (Boyd-Franklin, 1989), and agreeableness, gender, conscientiousness, personal interests, and extraversion (Vera, et al., 1999) are as or more important than therapist race/ethnicity.

However, many of the interview participants also believed that having a Black therapist could be beneficial to the therapeutic relationship. These interview participants recognized that there were similarities based on race and ethnicity that could increase a Black client's comfort in therapy. They explained that a Black therapist may have more familiarity with the Black culture and that greater familiarity would facilitate greater comfort and openness in therapy sessions. However, some of the interview participants believed that Black American culture could be learned and the human connection was more important. These findings suggest that Black clients who are less familiar with therapy may be comforted by at least having familiarity with a therapist's culture or race/ethnicity.

The Multidimensional Model of Racial Identity (Sellers, et al., 1998) may help to explain the lack of preference for a Black therapist for most of the interview participants. Again, the interview participants generally had low racial centrality. They also generally espoused humanist and assimilation beliefs and had less minority and national beliefs. Thus, they would have been less likely to look for racial commonalities in the therapist, and more likely to look for the common characteristics that human beings share, such as the ability to provide warmth and comfort.

All of the interview participants reported that they were satisfied with therapeutic services at the university clinic. Also, all of the interview participants had positive perceptions of their therapist, regardless of therapist race or ethnicity. This finding supports the results of Murphy and Faulkner (1999). Murphy and Faulkner, in a review

of records, found clients at a university clinic reported satisfaction with their therapy experience, no matter the race of the therapist.

This study's finding is not consistent with the literature that suggests that Black Americans experience racism and/or discrimination during the therapeutic process. Generally, all of the interview participants reported that they perceived their experience of therapy to be impartial and fair. Writers in the field contend that racism and discrimination continue to interfere with the therapeutic process (Erskine, 2002; Priest, 1991; Surgeon General, 1999). According to the Critical Race Theory, racism continues to invade the fabric of American society (Delgado & Stefancic, 1989). This finding may represent an on-going change in American society with regard to the decreasing importance of race, as American society grows multi-culturally. Also, it may reflect the diversity of the area in which the university clinic is located and the diversity of values within the Black community. It is possible that these are middle-income Blacks that identify with White, middle-income values. Or, this finding suggests that the therapist interns at the university clinic are well-trained and nurtured under an environment that accepts diverse clientele.

It is important to note that one interview participant questioned whether or not actions taken in the therapy process were precipitated by bias due to race or income. This interview participant, however, also reported an overall positive experience at the university clinic. Thus, this situation, unfortunately, may stand to remind us that perceived bias is still a possibility in the therapeutic relationship.

The framework of the Multidimensional Model of Racial Identity (Sellers, et al., 1998) may help us understand these findings; it is possible that for the interview participant discussed above who was a parent of a family with great needs, the parental role identity may have been more prominent than her racial identity at the beginning of the therapeutic process. Later, the actions taken in therapy may have caused race to become more central to the interview participant's identity. Thus, as the theory of MMRI asserts, as situations changed in the therapy process the interview participant's racial identity (or class identity) may have become more salient than her parental role identity and caused race to become more central to her self-identity.

Generally, the interview participants were not high on racial centrality. It is possible that for many of these interview participants, due to their regional backgrounds, middle class status, and the location of the university clinic (in a predominately, White American, high-income, but diverse area), the stable component of their racial identity involves low racial centrality. However, new situations that evolve during the therapy process may precipitate greater racial salience. It may be that in the beginning of treatment, familial role identities are foremost to their self-identity and race less salient due to the severity of the presenting problems in the beginning of treatment. Thus, there is room for other identities, such as racial identity, to move to the forefront of their self-identity later in the therapy process.

All of the interview participants were, generally, satisfied with the physical environment of the university clinic. There is not any literature confirm or disconfirm this finding. It was speculated that due to the university environment and American history of maltreatment of Black Americans in an institutional setting, Black Americans may be more reluctant to attend therapy at the university clinic. However, several of the interview participants did express some concern for the training equipment used in the therapy room as part of live supervision set-up of the university clinic to train the therapist interns, such as unease and distraction. Yet, they were able to recognize the educational value of the training equipment/live supervision. This is consistent with the results of Locke and McCollum (2001) who surveyed 108 clients at the university clinic about their experience of live supervision and therapy at the university clinic. They reported that the clients generally reported satisfaction with the therapy and the live-supervision process, as long as the benefits of the live supervision were greater than the perceived intrusiveness.

This study also found gender differences among the interview participants. Some of the women in the study discussed the importance of being strong or independent. This adds support to the literature that suggests that many Black American women are expected to be strong and persevere in midst of struggles (Boyd-Franklin, 1995; Few, 1999; McNair, 1992). However, these women were willing to seek therapeutic treatment, which is not consistent with the literature about Black American women. According to writers in the field, these expectations tend to hinder Black American women from

seeking help (Few, 1999; Jordan, 1991; McNair, 1992). The female interview participants may have been more willing to seek therapy due to increased severity of the problem. These women also had female family, friends, and associates that were supportive of therapeutic treatment.

The male interview participants showed concern for their family. As Franklin (1993) suggested, these Black men were willing to seek therapy for the sake of their family. Otherwise, they are reluctant to seek help outside of the traditional support network and to self-disclose. Although expressing some concern about self-disclosure, all of the male interview participants were motivated to seek treatment for their family and/or partner relationships. This finding also supports other literature that reports Black men value family (Bowman, 1993).

Limitations of the Study

There were some limitations to this study. In the following pages, I will discuss these limitations. I will discuss the lack of generalizability, lack of follow-up, and the need for further in-depth investigation of some intra-group differences among Black American clients.

First, there was a small sample size of Black American participants in the study. This necessitates some caution when applying the results of this study to other Black American clients. However, this small sample size is also representative of the small number of Black Americans that sought therapy at the university clinic. While small sample sizes are standard in qualitative investigations, it is still imperative to note that the findings of the qualitative investigation do not represent all Black American clients in marriage and family therapy, but allows clinicians and researchers to speculate from these experiences about how other Black American clients may experience marriage and family therapy.

Second, this study would have benefited from a more iterative process of qualitative investigation. I did not follow-up with interviewees on questions that were left unanswered or answers that were unclear. For example, some of the interview participants explained that it would be expeditious to have a Black American therapist for "ethnic issues." However, there was not a quick, follow-up after the interviews to gather

more clear and consistent information about the interviewees' experience in therapy at the university clinic.

Third, this study did not investigate changes in session evaluation over time. This would have provided helpful information. However, many of the participants did not fill-out a second Session Evaluation Questionnaire (Stiles, 2000). This was due to therapist error and/or drop out of participants. However, this piece of information would have added a valuable component to this study.

Fourth, this study only examined the perceptions of Black Americans that came to therapy. Thus, this study pertains only to Black Americans that attend therapy. It does not allow for speculation about other Black Americans' views of therapy.

Implications for Future Research

It would be beneficial for another study to evaluate, more closely, differences among Black clients with regards to socioeconomic status, regional background, and presenting problems and how these differences impact therapeutic experience. As well, it would be beneficial to evaluate their interactions. For as this study has postulated, it is possible that racial identity is affected by regional differences. Writers in the field have pointed out that there are important intra-group differences among the Black American community members. The interview participants of this study exhibited some similarities but also had some important differences that need further investigation. Variations in socioeconomic status, regional background, and presenting problems influence client perceptions of therapy and race in therapy.

This study also found that Black American clients experience therapy differently from White American clients and have culturally different backgrounds that influence perceptions of therapy. Thus, this study adds support for the importance of examining the experience of Black Americans. Although there may be similarities with other clients, there are important differences that need further exploration.

Finally, the results of this thesis affirm the importance of allowing the client to speak out about their experience in therapy. The client brings unique perspectives that are many times lost in questionnaires. Qualitative investigations will help make the invisible visible in marriage and family therapy. This would provide researchers and

clinicians with guidance about what is helpful for Black American clients; thus, adding to our understanding about the Black American experience in marriage and family therapy.

Clinical Implications

These findings suggest that most Black American clients arrive at therapy with a family or community background that has negative perceptions of therapy. They are also likely to be unfamiliar with the therapy process, but expect active and directive support from the therapist in the therapy room. Thus, it is important for clinicians to understand a Black American client's experience and perception of therapy. It might be beneficial for clinicians to address a Black client's perceptions and previous experiences of therapy in the beginning of treatment. The client with little or no experience of therapy may benefit from some education about the clinician's style of therapy and what to expect of the therapy process. This would allow the clinician to help the client feel more comfortable in sessions.

Those clinicians that use competency-based approaches may want to acknowledge the strength, courage, and love that may motivate many Black American clients to come to therapy, despite negative perceptions from family and community. Especially Black American men may be willing to come to therapy to protect their family or partner relationship, but continue to harbor anxiety about self-disclosure in therapy. Acknowledging the strength, love, and courage it took to seek therapy may help them to feel more comfortable with participating in therapy. Similarly, it would be important to recognize the strength and determination of Black American female clients as they overcome personal and familial obstacles. Also, it might beneficial for clinicians to acknowledge any concerns that Black clients may have about seeking therapy and/or concerns about feelings of vulnerability in therapy sessions as a sign of weakness.

It would be imperative for clinicians to remember that Black Americans may enter treatment after the presenting problem has become severe or after a crisis. Although some may be referred by community agencies, those that seek treatment may have already considered the need for professional help, especially if clients are more educated and the problem has persisted for a sustained period of time. Thus, it is important that therapists assess how eager Black American clients are to begin problem

resolution to determine how to pace the therapy sessions. For example, if the client has been putting off going to therapy, the increase in presenting problem severity may have motivated them to finally seek therapy or may have caused a community agency to intervene and refer them for services; thus, they may be reluctant to join in the first session and desire to begin resolving the problem right away. With discussion, a therapist can determine if the client needs a faster pace in therapy to begin problem resolution.

Church and family are important to most Black American clients and can be a resource to the therapeutic process. It is helpful for clinicians to keep in mind that Black American clients that enter treatment are more likely to have support from the traditional support network, such as church, family, or friends. Family therapists can help clients access these resources; however, it is important to remember that some Black clients may have had different experiences with the church, family, or friends being supportive of therapy. Thus, is imperative that therapists listen to how clients want these resources involved their treatment. For instance, some of these interview participants explained that some family members responded negatively to their disclosure of therapy participation and some explained that they were concerned about confidentiality with the use of their church pastor for help. Thus, it may be beneficial for clinicians to openly discuss with their Black clients if, and how, these resources could aid the therapeutic process, without assuming that Black would want other family members and their church pastor involved in the treatment process.

Despite the similarities among Black American clients, it is important for therapists to pay attention to important differences among their Black American clients. Black American clients vary in age, religious beliefs, socioeconomic status, region or country of origin, and racial identity. It is important to recognize these cultural differences because they will affect the client's perception of therapy and the therapist. Those Black American clients for which race is more central to their identity, race of the therapist will initially be important to the client's ease in therapy. Thus, these clients take a little more time to get comfortable with a non-Black therapist. Clients that espouse more humanistic views and for whom race is not as central to their identity may be less

likely to prefer a Black American therapist and more likely to feel more comfortable with a non-Black therapist.

These findings suggest that Black Americans need more avenues for seeking help. It seems that those that are middle-income, more educated, and espouse more humanist and assimilation views are more likely to seek therapy. Also, those that have more severe problems seem to be more likely to seek therapy. Despite what the literature says, some Black Americans may not feel comfortable seeking their pastor during times of need. Thus, it is imperative that the mental health system and clinicians help to create more avenues for Black Americans to seek help during distress.

Yet, it is still vital to the marriage and family therapy field to have Black American therapists, in order to facilitate greater comfort, thus quicker problem resolution for those Black American clients that prefer a Black American therapist. Although, some may not prefer a Black American therapist, for some Black Americans, having a Black therapist facilitates a more comfortable transition into the therapeutic process. If potential Black Americans see the marriage and family therapy field as representative of the diversity of racial/ethnic groups in this nation, then they may more readily accept family therapy as a viable resource for all persons, despite therapist-race preference, in the Black American community.

Finally, it is most important to Black American clients that the therapist is skilled to facilitate comfort in the therapy room, knowledgeable enough to understand the dynamics of the Black American culture, and competent enough facilitate problem resolution, which is their primary goal. This means that it is important for therapists to be knowledgeable of Black American culture and the needs of Black American clients to develop the skill, knowledge, and competence to bring forth successful therapeutic outcome for Black American clientele.

<div align="center">Researcher's Response</div>

Black Americans in the past have demonstrated the necessary strength and courage to overcome racism and discrimination. These Black American clients have once again exhibited this strength and courage to overcome obstacles to greater life fulfillment by seeking therapy, despite the stigma, with the help of love for family and

self and their faith. They have shown me that there is a new struggle for the Black American community that starts within. They reminded me that I also have the strength to overcome. I say "Thank You" to them all.

"I am overwhelmed by the grace and persistence of my people." –Maya Angelou, 1992

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<center>**Appendix A**</center>

<center>**Informed Consent for Research Project**</center>

Project Title: The Therapeutic Experiences of Clients in a University Marriage and
Family Therapy Clinic

Researchers: Nikkiah E. Wyatt, M. S. Candidate, Department of Human Development,
Virginia Tech
Sandra M. Stith, Professor, Department of Human Development, Virginia
Tech

What is the purpose of this study? The purpose of this study is to find out how clients
experience therapy sessions in a university clinic. We would like to understand how
therapists could be more helpful to their clients.

What will I be asked to do? There two parts to this study. First, you will be asked
to fill out 1 short questionnaire after your first session and after your third session at the
Center for Family Services (CFS). Second, you may be selected to participate in a
face-to-face interview, which will take about one hour. The interview will be scheduled
at your convenience. We will ask you to explain how you experienced therapy sessions
at CFS and what therapists may be able to do different to be more helpful in the future.
The face-to-face interviews will be audiotaped to make sure we understand exactly what
you said.

Are there any risks to me? The researchers anticipate that this study will be low risk
due to the precautions that will be taken to ensure that your information will be kept
confidential. Your therapist will not know how you respond during the study.

Are there any benefits to me? As a result of participating in this study you may feel
empowered and feel a sense of satisfaction because you have contributed to an important
study that will benefit society.

Are my responses confidential? The information that you provide will not be attached
to your name or your case number given to you at CFS. Thus, your therapist will not
know how you responded to any questions. You will be given a false name or a number
and any identifying information will be erased. Your responses will be kept under lock
and access will only be allowed to the researchers listed above or to authorized research
assistants. After the study has been completed your name or any other identifying
information will not be reported in any publications or presentations.

However, if you are dangerous to yourself or others, or if there is a suspicion of child
or elder abuse, mental health professionals have the responsibility to report information
to appropriate persons with or without your consent.

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Will I be compensated for my participation? In appreciation for your time, we will pay $25 to each individual, couple, or family that participates in the face-to-face interview. No other compensation will be given.

Do I have the freedom to withdraw? You have the right to refuse to participate at any stage in this study.   You also have the right to refuse to answer any questions. Your decision to participate will not affect the services you receive at CFS.

Approval of Research: This project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic and State University.

If you have any questions about this research project, please feel free to contact:

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Dr. David Moore, IRB Chair
540-231-4991, moored@vt.edu

Participant's Permission:

I voluntarily agree to participate in this research project. I have read and understand the Informed Consent and the conditions of this project. I hereby acknowledge the above and give my voluntary consent for participation in this project by signing my name on the line below. I realize that, although I choose to participate right now, I have the right to withdraw from this study at any time without any penalty.

Printed Name: _____

Signature: _____

Date: _____

Printed Name: _____

Signature: _____

Date: _____

Case # _____   Age _____   Gender _____   Date:_____

Session Evaluation Questionnaire

Please circle the appropriate number to show how you feel about this session.

This session was:

bad	1	2	3	4	5	6	7	good
difficult	1	2	3	4	5	6	7	easy
valuable	1	2	3	4	5	6	7	worthless
shallow	1	2	3	4	5	6	7	deep
relaxed	1	2	3	4	5	6	7	tense
unpleasant	1	2	3	4	5	6	7	pleasant
full	1	2	3	4	5	6	7	empty
weak	1	2	3	4	5	6	7	powerful
special	1	2	3	4	5	6	7	ordinary
rough	1	2	3	4	5	6	7	smooth
comfortable	1	2	3	4	5	6	7	uncomfortable

Right now I feel:

happy	1	2	3	4	5	6	7	sad
angry	1	2	3	4	5	6	7	pleased
moving	1	2	3	4	5	6	7	still
uncertain	1	2	3	4	5	6	7	definite
calm	1	2	3	4	5	6	7	excited
confident	1	2	3	4	5	6	7	afraid
friendly	1	2	3	4	5	6	7	unfriendly
slow	1	2	3	4	5	6	7	fast
energetic	1	2	3	4	5	6	7	peaceful
quiet	1	2	3	4	5	6	7	aroused

Center for Family Services

COUPLE/FAMILY BACKGROUND FORM

NAME: _____ DATE:_____

ADDRESS: _____

_____

PHONE (Home):_____(Work):_____ (Cell):_____

Date of Birth: _____ ETHNICITY: _____

RELIGION: _____ HIGHEST GRADE OF EDUCATION: _____

PRESENT MARITAL STATUS: ___ Single ___ Living together ___ Engaged

___ Married ___ Separated ___ Divorced ___ Remarried ___ Widowed

SPOUSE/PARTNER'S NAME: _____ DOB: _____

SPOUSE/PARTNER'S RELIGION: _____ ETHNICITY: _____

SPOUSE/PARTNER'S HIGHEST GRADE OF EDUCATION: _____

Number of years married/together: _____

Were there any previous marriages for either spouse/partner? _____ How many? _____

Self: _____ Duration of each: _____ Partner: _____ Duration of each: _____

Gross Annual Income of Household: _____

WHO IS LIVING IN YOUR RESIDENCE?

Name:	Age	Relationship

In case of an emergency, the Center for Family Services may contact:

NAME: _____

Relationship: _____

ADDRESS: _____

PHONE: (home)_____ PHONE: (work)_____

CHILDREN NOT LIVING AT HOME:

Name	Age

MEDICAL HISTORY:

Family Physician's Name: _____ Phone: _____

Do you or anyone in your family have any known medical problems, either current or past? If yes, please describe:

_____

_____

_____

Are you or anyone in the family currently taking any medication? If yes, please list medications here.

_____

_____

_____

FAMILY HISTORY:
Have there been any deaths in the immediate family? Please list by name and relationship and identify when these occurred.

_____

_____

_____

Has anyone in your family or your partner's family ever attempted suicide? If yes, please explain.

_____

_____

_____

Has anyone in your family ever expressed concern about another family member's use of alcohol or drugs? If so, please explain.

_____

_____

_____

How much do you drink and how often? _____

How much does your partner drink and how often? _____

Has anyone ever expressed concern about the way in which anger is managed in your family? If yes, please explain or give example(s).

_____

_____

_____

Has anyone in the family ever had conflicts that resulted in physical confrontation? For example: pushing shoving, hitting, punching. If yes, please explain.

_____

_____

_____

Have you or anyone in your family ever been involved in the court system? If yes, please explain.

_____

_____

_____

Please describe briefly the most important problems for which you would like help:

_____

_____

_____

How were you referred to us?
Name of referral source: _____ Title: _____

Agency: _____ Phone #: _____

Appendix D

Checklist Form

Case # _____

Please list all adults expected to attend therapy.

Name	Gender (M/F)	Age	Race	Consent (Y/N)	SEQ (Y/N)
1.					
2.					
3.					
4.					

Did all clients <u>18 years old or older</u> get an opportunity to sign the informed consent?_____

Please remember to put the informed consent form(s) and checklist form in Nikki's Thesis box.

Thanks Again!!!

Appendix E

Demographic Questionnaire

Please circle or write your responses. Thank you.

What Socioeconomic status (SES) do you consider yourself to be, financially?

   a. lower class
   b. lower-middle class
   c. upper-middle class
   d. upper class

In regards to race/ethnicity, how do you prefer to be identified?

   a. Black
   b. African American
   c. Negro
   d. Colored
   e. It does not matter which one

What is your age?

What is your gender?   Male   Female

Which best describes your level of education?

   a. Less than high school education
   b. High school education/GED
   c. Some college/technical school
   d. Completed college/technical school
   e. Some graduate/advanced degree education
   f. Completed graduate/advanced degree education

Appendix F

Interview Guide

Introduction – Name, purpose of research/interview, limitations of confidentiality

Experience Initiating Therapy

What was his/her thoughts/feelings about coming to therapy? [Have you ever been in therapy? Why did you begin therapy at the Center for Family Services? Who gave you the contact? What were your thoughts while initiating therapy (making phone calls, selecting)? When you found out that it was apart of Virginia Tech, how did it influence your decision to call or attend? What were your feelings during the initiation of therapy? Has any family/friends been in therapy before? Were they or would they be supportive of therapy? Did any religious affiliation make it difficult or easier for you to pursue therapy? What did you expect to happen in therapy? Did you try other ways to resolve the problem? What did you try?]

Experience of the Therapy Environment

How did the university/research-oriented environment of the building, waiting room, and the therapy room effect thoughts/feelings about therapy? [What impressions did the building (educational institution, large, long white hallways) give you about what the therapy process would be like? What impressions did you have of what therapy would be like when you entered the waiting area (no receptionist, arrangement, decoration, meeting therapist)? What impressions did you have of therapy while you were in the therapy room (video, phone, one-way mirror)?]

Experience in Therapy

What was his/her thoughts/feelings during therapy sessions? [Was your experience of therapy how you expected it to be? As a minority/African-American/Black person, what thoughts/feelings did you have about the therapy in general? experience at CFS? How has the CFS affiliation with a university (research-oriented institution) influenced your experience? Do you think something should be different in your experience? What advice do you have for your/a therapist, in order to make the therapy experience more comfortable for other African Americans/Blacks? Do you think that it would have been helpful to have an African-American therapist? Is there any issue that it would be helpful for?]

Continuation/Termination of Therapy

Why does he/she discontinue/continue treatment? [What aspects of therapy influences your decision to continue/discontinue? What factors outside of therapy influence your decision?]
Anything that you want to add?

SCORING INSTRUCTIONS FOR THE MULTIDIMENSIONAL INVENTORY OF BLACK IDENTITY (MIBI)

Reverse score all items that have a (R) next to them by subtracting 8 from each individuals' score on the item. Next, average the scores for each of the items within a particular subscale. DO NOT CREATE A SUM SCORE FOR THE ENTIRE SCALE. Because the MIBI is based on multidimensional conceptualization of racial identity, a composite score from the entire scale is inappropriate.

CENTRALITY ITEMS (8): 1(R), 6, 9, 13 (R), 19, 33, 48, 51 (R)

PRIVATE REGARD ITEMS (6): 4, 7, 8, 24 (R), 54, 55

PUBLIC REGARD ITEMS (6): 5, 15, 17 (R), 52 (R), 53, 56

ASSIMILATION ITEMS (9): 10, 18, 37, 39, 40, 41, 43, 44, 46

HUMANIST ITEMS (9): 23, 26, 27, 28, 29, 30, 31, 32, 35

MINORITY ITEMS (9): 20, 34, 36, 38, 42, 45, 47, 49, 50

NATIONALIST ITEMS (9): 2, 3, 11, 12, 14, 16, 21, 22, 25

Multidimensional Inventory of Black Identity (MIBI)

	Strongly Disagree			Neutral			Strongly Agree
1. Overall, being Black has very little to do with how I feel about myself.	1	2	3	4	5	6	7
2. It is important for Black people to surround their children with Black art, music and literature.	1	2	3	4	5	6	7
3. Black people should not marry interracially.	1	2	3	4	5	6	7
4. I feel good about Black people.	1	2	3	4	5	6	7
5. Overall, Blacks are considered good by others.	1	2	3	4	5	6	7
6. In general, being Black is an important part of my self-image.	1	2	3	4	5	6	7
7. I am happy that I am Black.	1	2	3	4	5	6	7

	Strongly Disagree			Neutral			Strongly Agree
8. I feel that Blacks have made major accomplishments and advancements.	1	2	3	4	5	6	7
9. My destiny is tied to the destiny of other Black people.	1	2	3	4	5	6	7
10. Blacks who espouse separatism are as racist as White people who also espouse separatism.	1	2	3	4	5	6	7
11. Blacks would be better off if they adopted Afrocentric values.	1	2	3	4	5	6	7
12. Black students are better off going to schools that are controlled and organized by Blacks.	1	2	3	4	5	6	7
13. Being Black is unimportant to my sense of what kind of person I am.	1	2	3	4	5	6	7
14. Black people must organize themselves into a separate Black political force.	1	2	3	4	5	6	7
15. In general, others respect Black people.	1	2	3	4	5	6	7
16. Whenever possible, Blacks should buy from other Black businesses.	1	2	3	4	5	6	7
17. Most people consider Blacks, on the average, to be more ineffective than other racial groups.	1	2	3	4	5	6	7
18. A sign of progress is that Blacks are in the mainstream of America more than ever before.	1	2	3	4	5	6	7
19. I have a strong sense of belonging to Black people.	1	2	3	4	5	6	7
20. The same forces which have led to the oppression of Blacks have also led to the oppression of other groups.	1	2	3	4	5	6	7
21. A thorough knowledge of Black history is very important for Blacks today.	1	2	3	4	5	6	7
22. Blacks and Whites can never live in true harmony because of racial differences.	1	2	3	4	5	6	7

	Strongly Disagree			Neutral			Strongly Agree
23. Black values should not be inconsistent with human values.	1	2	3	4	5	6	7
24. I often regret that I am Black.	1	2	3	4	5	6	7
25. White people can never be trusted where Blacks are concerned.	1	2	3	4	5	6	7
26. Blacks should have the choice to marry interracially.	1	2	3	4	5	6	7
27. Blacks and Whites have more commonalties than differences.	1	2	3	4	5	6	7
28. Black people should not consider race when buying art or selecting a book to read.	1	2	3	4	5	6	7
29. Blacks would be better off if they were more concerned with the problems facing all people than just focusing on Black issues.	1	2	3	4	5	6	7
30. Being an individual is more important than identifying oneself as Black.	1	2	3	4	5	6	7
31. We are all children of a higher being, therefore, we should love people of all races.	1	2	3	4	5	6	7
32. Blacks should judge Whites as individuals and not as members of the White race.	1	2	3	4	5	6	7
33. I have a strong attachment to other Black people.	1	2	3	4	5	6	7
34. The struggle for Black liberation in America should be closely related to the struggle of other oppressed groups.	1	2	3	4	5	6	7
35. People regardless of their race have strengths and limitations.	1	2	3	4	5	6	7
36. Blacks should learn about the oppression of other groups.	1	2	3	4	5	6	7

	Strongly Disagree		Neutral			Strongly Agree
37. Because America is predominantly white, it is important that Blacks go to White schools so that they can gain experience interacting with Whites.	1	2	3	4	5	6	7
38. Black people should treat other oppressed people as allies.	1	2	3	4	5	6	7
39. Blacks should strive to be full members of the American political system.	1	2	3	4	5	6	7
40. Blacks should try to work within the system to achieve their political and economic goals.	1	2	3	4	5	6	7
41. Blacks should strive to integrate all institutions which are segregated.	1	2	3	4	5	6	7
42. The racism Blacks have experienced is similar to that of other minority groups.	1	2	3	4	5	6	7
43. Blacks should feel free to interact socially with White people.	1	2	3	4	5	6	7
44. Blacks should view themselves as being Americans first and foremost.	1	2	3	4	5	6	7
45. There are other people who experience racial injustice and indignities similar to Black Americans.	1	2	3	4	5	6	7
46. The plight of Blacks in America will improve only when Blacks are in important positions within the system.	1	2	3	4	5	6	7
47. Blacks will be more successful in achieving their goals if they form coalitions with other oppressed groups.	1	2	3	4	5	6	7
48. Being Black is an important reflection of who I am.	1	2	3	4	5	6	7
49. Blacks should try to become friends with people from other oppressed groups.	1	2	3	4	5	6	7

	Strongly Disagree			Neutral			Strongly Agree
50. The dominant society devalues anything not White male oriented.	1	2	3	4	5	6	7
51. Being Black is not a major factor in my social relationships.	1	2	3	4	5	6	7
52. Blacks are not respected by the broader society.	1	2	3	4	5	6	7
53. In general, other groups view Blacks in a positive manner.	1	2	3	4	5	6	7
54. I am proud to be Black.	1	2	3	4	5	6	7
55. I feel that the Black community has made valuable contributions to this society.	1	2	3	4	5	6	7
56. Society views Black people as an asset.	1	2	3	4	5	6	7

Appendix H

Virginia Tech

VIRGINIA POLYTECHNIC INSTITUTE
AND STATE UNIVERSITY

Institutional Review Board

Dr. David M. Moore
IRB (Human Subjects) Chair
Assistant Vice Provost for Research Compliance
CVM Phase II - Duckpond Dr., Blacksburg, VA 24061-0442
Office: 540/231-4991; FAX: 540/231-6033
e-mail: moored@vt.edu

MEMORANDUM

TO: Nikkiah Wyatt HD 0362
Sandra Stith   HD 0362

FROM: David M. Moore

DATE: June 11, 2002

SUBJECT: **Expedited Approval** – "The Experience of African American Clients in Family Therapy" – IRB #02-307

This memo is regarding the above-mentioned protocol. The proposed research is eligible for expedited review according to the specifications authorized by 45 CFR 46.110 and 21 CFR 56.110. As Chair of the Virginia Tech Institutional Review Board, I have granted approval to the study for a period of 12 months, effective June 11, 2002.

Approval of your research by the IRB provides the appropriate review as required by federal and state laws regarding human subject research. It is your responsibility to report to the IRB any adverse reactions that can be attributed to this study.

To continue the project past the 12 month approval period, a continuing review application must be submitted (30) days prior to the anniversary of the original approval date and a summary of the project to date must be provided. My office will send you a reminder of this (60) days prior to the anniversary date.

cc:File

Appendix I

Research Assistant/Transcriber Confidentiality Form

I, _____, do understand that the information revealed by current and /or former clients from the Center for Family Services of Virginia Tech on the audiotapes that I will be transcribing is confidential and agree to respect their confidentiality by abstaining from identifying or discussing any this information with others besides the principal researchers. I do agree to notify the principal researcher when I recognize the person(s) based on the voice or identifying information revealed and agree to discontinue transcribing that case immediately.

_____   _____
Transcriber Signature   Date

_____   _____
Witness Signature   Date

Nikkiah E. Wyatt

9411 Lee Hwy, #505, Fairfax, VA 22031
571-432-0126 (home), 703-538-8310 (work), nwyatt@vt.edu (email)

EDUCATION:

2000- 2003, Virginia Polytechnic Institute and State University, Falls Church, VA
M.S. in Human Development, Marriage and Family Therapy Program

1995-1999, University of Tennessee, Knoxville, TN
B.A. in Psychology, Graduated Summa Cum Laude

CLINICAL EXPERIENCE:

Therapist Intern, September 2002 – May 2003

Center for Multicultural Human Services, Falls Church, VA

Provided brief individual therapy services and case management to children and adolescents and their families from diverse racial/ethnic backgrounds in the school system. Developed and implemented treatment plans. Conducted risk assessment. Fulfilled administrative duties and maintained client files. Coordinated services with school personnel and other community agencies. Co-facilitated a brief family therapy group for adolescents and their families.

Therapist Intern, May 2001-May 2003

Center for Family Services, Virginia Tech, Falls Church, VA

Provided brief individual, couple, and family therapy to the community and individuals with serious mental illnesses. Populations were diverse and included children and adolescents. Duties also included crisis intervention, intake assessment which included providing a multi-axial DSM diagnosis, and interagency collaboration.

Co-Facilitator/Teacher, 2002-2003

Virginia Tech Couples Conflict Group, Falls Church, VA

Taught 6-week anger management class. Co-facilitated a 12-week group for couples with domestic violence issues. Fulfilled administrative duties and maintained client files. Coordinated services with other mental health and social service professionals.

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Psyche Tech, Summer 2002

INOVA Kellar Center, Fairfax, VA

Implemented behavior-management system, co-facilitated groups, and used crisis intervention skills in a summer day treatment program for children with serious mental illness and trauma.

Mentor, 2001- 2002

INOVA Kellar Center, Fairfax, VA

Developed a relationship with pre-adolescents with social problems, serious mental illnesses, and history of trauma to help them build social skills through various social activities. Coordinated services with other mental health team members.

Liaison Counselor, August 1999- August 2000

Helen Ross McNabb Center, Knoxville, TN

Provided individual, group, and family counseling for children and adolescents with serious mental illnesses in the school system. Duties included case management, interagency collaboration, and medication monitoring in the home and school.

Child and Family, Inc., Haslam Center, Knoxville, TN

Associate Teacher/Counselor, 1997-2000

Assisted in the oversight of the daily activities of sexually abused adolescents with serious mental illnesses in a residential treatment facility. Duties included behavioral management, crisis intervention, and administrative duties.

RESEARCH EXPERIENCE:

Research Assistant, Angela J. Huebner, Ph.D., June 2002-May 2003

Virginia Adolescent Resiliency Assessment, Virginia Cooperative Extension, Virginia Polytechnic Institute and State University, Department of Human Development

PAPERS:

Huebner, A. J., Morgan, E., & Wyatt, N. (2002). *Risk and Resilience: Positive youth development in West Point, Virginia.* Unpublished manuscript, Virginia Polytechnic Institute and State University.

Huebner, A. J., Morgan, E., & Wyatt, N. (2002). *Risk and Resilience: Positive youth development in Gloucester, Virginia*. Unpublished manuscript, Virginia Polytechnic Institute and State University.

Huebner, A. J. & Wyatt, N. (2002). *Risk and Resilience: Positive youth development in Middle Peninsula-Northern Neck, Virginia.* Unpublished manuscript, Virginia Polytechnic Institute and State University.

Huebner, A. J. & Wyatt, N. (2002). *Risk and Resilience: Positive youth development in Orange County, Virginia*. Unpublished manuscript, Virginia Polytechnic Institute and State University.

Huebner, A. J. & Wyatt, N. (2003). *Risk and Resilience: Positive youth development in Fredericksburg, Virginia*. Unpublished manuscript, Virginia Polytechnic Institute and State University.

Huebner, A. J. & Wyatt, N. (2003). *Risk and Resilience: Positive youth development in King & Queen County, Virginia, II.* Unpublished manuscript, Virginia Polytechnic Institute and State University.

VOLUNTEER EXPERIENCE:

Resource Person, 2001
National Alliance for the Mentally Ill, Family-to-Family Education Program

Organizer/Representative, 2000-Present
Graduate Student Association at the Northern Virginia Center

RECOGNITIONS/HONORS:

Phi Eta Sigma National Honor Society

Gamma Beta Phi National Honor Society

Golden Key National Honor Society

Psi Chi National Honor Society

American Association for Marriage and Family Therapists Minority Fellowship Award

PROFESSIONAL ORGANIZATIONS:

American Association for Marriage and Family Therapy, Student Member since 2001